Our family exists to care for yours.

Heritage Hall – Clintwood • 1225 Clintwood Main Street • P.O. Box 909 • Clintwood, VA 24228
(P) 276.926.4693 • (F) 276.926.9128

January 9, 2017

Center for Quality Health Services and Consumer Protection
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attention: Rodney Miller, Long Term Care Supervisor
Richmond, VA 23233-1463

Mr. Miller,

Attached to this cover letter you will find Heritage Hall - Clintwood's Plan of Correction and our credible allegation of compliance. The Plan of Correction addresses the corrective action, identification of deficient practices, systemic changes and monitoring that will be implemented to address deficient practices identified during our annual survey.

If I can be of further assistance don't hesitate to contact me at (276)926-4693.

Sincerely,

Glenna Kennedy

Glenna Kennedy
Administrator

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HERITAGE HALL
HEALTHCARE AND REHABILITATION CENTERS
Managed by AMERICAN HEALTHCARE, LLC

COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

December 27, 2016

Ms. Glenna Kennedy, Administrator
Heritage Hall Clintwood
1225 Clintwood Main Street
Route 607 P.O. Box 909
Clintwood, VA 24228

RE: Heritage Hall Clintwood
Provider Number 495320

Dear Ms. Kennedy:

An unannounced standard survey, ending December 15, 2016, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of E), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Rodney L. Miller, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at "http://www.vdh.state.va.us/OLC/longtermcare/".

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).

- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,

- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: "http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Rodney L. Miller, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joann Atkins, D M A S (Sent Electronically)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495320	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/13/16 through 12/15/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 100 certified bed facility was 86 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents #1 through #15 and #20) and 4 closed record reviews (Residents #16 through #19).	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272	**F272** **Corrective Action(s):** Resident #4 has had their Care Area Assessment Summary and Care Area worksheets revised to reflect the location of the of documentation to support the care plan decisions. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially affected. A 100% review of all resident's most current comprehensive MDS assessments and the Care Area Assessment Summary's will be completed by the RCC to identify residents affected. All residents affected will have their Comprehensive MDS assessments and Care Area Assessment Summary's corrected at time of discover and their comprehensive care plans updated.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed Glenna Kennedy | TITLE: Administrator | (X6) DATE: 1-9-2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate Care Area Assessment Summary (CAA) for 1 of 20 Residents, Resident #4. The findings included: For Resident #4 the facility staff failed to accurately name the date and location of CAA (care area assessment) documentation. Resident #4 was admitted to the facility on 07/16/15 and readmitted on 08/25/16. Diagnoses included but not limited to hypertension, urinary tract infection, hyperlipidemia, cerebrovascular accident, depression and end stage renal disease. The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 01/08/16 coded the Resident as 15 of 15	F 272	**Systemic Change(s):** The facility policy and procedure was reviewed and no changes are warranted at this time. The regional nurse consultant will inservice the Resident Care Coordinator's and the interdisciplinary Care Plan Team on accurately completely the Care Area Assessment Summary. This will include accurate documentation indicating the date and location of documentation describing each resident's clinical status and other factors that impact care planning. **Monitoring:** The RCC is responsible for maintaining compliance. The RCC will complete MDS audit tool weekly coinciding with the MDS calendar to monitor for compliance. Any/all negative findings will be reported to the RCC and the DON at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date:** **January 29, 2017**	

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F 272	Continued From page 2 in section C, cognitive patterns. Section V, care area assessment, was reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plans. The only documentation was "current care plan continued". The concern of the missing information on the CAA's was discussed with the administrative staff during a meeting on 12/15/16 at approximately 1245. No further information was provided prior to exit.	F 272		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review the facility staff failed to follow established professional standards of nursing practice for the administration of medications for 1 of 20 Residents, Resident #3. The findings included: For Resident #3 the facility staff held the long acting insulin, Toujeo, at the request of a family member and without notifying the physician. Resident #3 was admitted to the facility on 06/14/06 and readmitted on 03/14/13. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia,	F 281	**F281** **Corrective Action(s):** Resident #3's attending physician has been notified that the facility staff did not administer insulin per physician order and held resident #3's insulin without notifying the attending physician. Resident #3's physician order insulin has been reviewed to ensure all medication orders are accurate. A Facility Incident & Accident Form was completed for these incidents. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving insulin may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all resident's insulin orders to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each error. An Incident & Accident form will be completed for each negative finding.	

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F 281	Continued From page 3 hemiplegia, seizure disorder, anxiety, depression, psychotic disorder, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and end stage renal disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/13/16 coded the Resident as 2 out of 15 in section C, cognitive patterns. The Resident's CCP (comprehensive care plan was reviewed and contained a plan for diabetes which read in part "Problem Onset: 10/14/16 Endocrine Dx (diagnosis) : Diabetes. Goal and target date: ...will experience optimal glocuse levels over the next 90 days. Approaches: insulin as ordered." Resident #3's clinical record was reviewed on 12/14/16. It contained a signed POS (physician's order summary) dated 12/13/16 which read in part "TOUJEO SOLOSTAR 300 UNITS/ML GIVE 45ML SUBCUTANIOUS QAM (every morning) DX (diagnoses) DM TYPE II Generic: INSULIN GLARGINE, HUMAN RECOMBINANT ALALOG". The start date for this order was listed as 08/29/16. The Resident's MAR's (medication administration record) for the months of October, November and December 2016 were reviewed and contained an entry which read in part "TOUJEO SOLOSTAR 300 UNITS/ML GIVE 45ML SUBCUTANIOUS QAM DX (diagnoses) DM TYPE II". For the month of October, the MAR had been signed with "N" on the following dates: 10/01-10/03, 10/05, 10/11, 10/15-10/16, 10/24, 10/28, and 10/31. For November, the MAR had been signed with "N" on the following days: 11/04-11/08, 11/10-11/12, 11/14, 11/16, 11/18-11/19, 11/21-11/25, and 11/28-11/29. For the month of December the	F 281	**Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration to include giving at ordered time and physician notification if a medication is held or refused. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will review medication orders weekly coinciding with the care plan calendar in order to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **January 29, 2017**	

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F 281	Continued From page 4 MAR had been signed with "N" for 12/01-12/02, 12/05/12/06, 12/08-12/09, 12/11, and 12/14. The comments section of the MAR on the days signed with "N" read in part "TOUJEO SOLOSTAR 300UNITS/ML GIVE 45ML S... scheduled for ...was held.special requirement not met". The surveyor could not locate any physician's order to hold the Toujeo insulin or any nurse's notes stating the physician had been notified when the Toujeo had been held. The surveyor spoke with RN (registered nurse) #1 on 12/14/16 at approximately 1615 regarding Resident #3's insulin being held and what the "special requirement" was. RN #1 stated that the Resident's daughter did not want the Toujeo insulin given if Resident's blood sugar levels are below a certain level. Surveyor asked RN #1 below what level did the daughter want the Toujeo held, and RN #1 answered "below 150, 170 or thereabout". The surveyor spoke with LPN (licensed practical nurse) #3, who is Resident #3's daughter on 12/15/16 at approximately 1030 regarding holding the Toujeo. Surveyor asked LPN #3 why she requested her mother's insulin be held and she stated "She bottomed out on me one day and I just feel better about holding it". Surveyor then asked LPN #3 if she had discussed this with Resident #3's physician, and she stated that she had not. The concern of holding the insulin without a physician's order was discussed with the administrative team on 12/14/16 at approximately 1630. The surveyor requested the facility standards of practice regarding insulin administration at this time.	F 281		

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F 281	Continued From page 5 The DON (director of nursing) provided the surveyor with a copy of "Administering Medications" on 12/15/16 at approximately 0800, which read as follows: Policy Statement Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 3. Medications must be administered in accordance with the orders, including any required time frame. The surveyor was also provided with a copy of "Adverse Consequences and Medication Errors" which read as follows: Policy Interpretation and Implementation 5. A "medication error" is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing these services. 6. Examples of medication errors include: a. Omission-a drug is ordered but not administered. The RNC (regional nurse consultant) also provided the surveyor with a copy of the package insert information on Toujeo which read as follows: Patient Information TOUJEO (insulin glargine injection) for subcutaneous use, 300 Units/ml (U-300) How should I use TOUJEO? Use TOUJEO exactly as your healthcare provider	F 281		

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F 281	Continued From page 6 tells you to. Your healthcare provider should tell you how much TOUJEO to use and when to use it. Know the amount of TOUJEO you use. Do not change the amount of TOUJEO you use unless your healthcare provider tells you to. TOUJEO should be used 1 time each day and at the same time each day. The DON stated to the surveyor on 12/15/16, that she had spoken with Resident #3's physician on 12/14/16 regarding the administration of the Toujeo insulin and provided the surveyor with a copy of a nurse's note which read in part "12/14/16 6:10pm Phone conversation with Dr..... (name omitted) to clarify Toujeo order. Dr... stated that since Toujeo is a long acting insulin, it must be given on a consistent basis in order for the medication to do its job. Given the fact that Resident's fasting blood glucose has averaged 119, Dr... gives verbal order: Stop Toujeo 45 units QAM. Begin Toujeo 300 units/ml administer 35 units subcutaneous Q am. Keep fasting blood sugar log for next 48 hours and report to Dr... results. RP (responsible party) notified. Pharmacy notified." DON also provided the surveyor with a copy of the new physician's order reading the same. No further information was provided prior to ext.	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	**F309** **Corrective Action(s):** Residents #2's attending physician was notified that the facility failed to administer the pain medication Norco and the antibiotic Bactrim as ordered by the attending physician. A facility Medication Error form was completed for this incident.	

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F 309	Continued From page 7 and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide services for the highest practicable well-being for 6 of 20 Residents, Residents #2, #18, #3, #12, #6, and #14. The findings included. 1. For Resident #2, the facility staff failed to administer the pain medication norco and the antibiotic bactrim as ordered by the attending physician. The record review revealed that Resident #2 was admitted to the facility 06/09/15. Diagnoses included, but were not limited to, chronic pain syndrome, anemia, anxiety, osteoporosis, and dysphagia. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/31/16 included a BIMS (brief interview for mental status) score of 13 out of a possible 15 points. Section J (health conditions) was coded to indicate the Resident had no pain in the last 5 days. A). The Residents CCP (comprehensive care plan) included the problem area of pain. Approaches included administer medications as ordered and notify MD of any changes	F 309	Resident #18 is no longer in the facility. Resident #18's attending physician was notified that the facility staff failed to administer the antihypertensive medication Metoprolol as ordered by the physician while a resident in the facility. A facility Medication Error form was completed for this incident. Residents #3's attending physicians was notified that the facility failed to administer or follow the bowel protocol for resident #3 who did not have a bowel movement for 7 days in October, 5 days in November & 5 days in December as ordered by the physician. A facility Incident and Accident form was completed for this incident. Resident #12's attending physician was notified that the facility staff failed to administer PRN Zofran medication for nausea per physician order. A facility Medication Error form was completed for this incident. Residents #6's attending physicians was notified that the facility failed to discontinue a pain medication and start a new pain medication per physician order. A facility Medication Error form was completed for this incident. Residents #14's attending physician was notified that the facility staff failed to administer Florajen Bifidoblend as ordered by the physician. A facility Medication Error form was completed for this incident.	

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F 309	Continued From page 8 The clinical record included the following. A physicians order dated 11/30/16 and signed by the physician to "Discontinue Norco 5mg tabs...Start Norco 7.5/325 mg tab 1 po (by mouth) BID (twice a day) pain." Physician's progress transcribed by the physician and dated 11/30/16 that read in part "...CPS-will increase Norco to 7.5 mg po BID + follow..." A review of Resident #2's eMAR's (electronic medication administration records) for December 2016 indicated that the facility had been administering Norco 7.5-325 tablet 1 po q (every) 6 hours not BID. The clinical record included a nursing note transcribed by LPN (licensed practical nurse) #2 that read "New MD orders to D/C (discontinue) Lortab 5mg when exhausted on Sat and begin Norco 7.5/325 mg one po Q6 hours for pain RP (responsible party) agrees Dr. _____ here to see resident and sign recert." A review of the Residents eMAR's for October and November 2016 was completed and the surveyor was unable to locate any documentation to indicate the facility nursing staff had administered any prn (as needed) pain medication for either month. The surveyor also reviewed the nursing notes for the entire month of November 2016 and was unable to locate any documentation to indicate the Resident had complained of pain. On 12/13/16 at approximately 3:20 p.m. LPN #2 was asked about the conflicting information regarding the Norco dosage. After reviewing the orders with the surveyor LPN #2 stated there was a "script" that had accompanied the order. LPN	F 309	**Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician orders, medication orders, treatment orders. To include following the bowel protocol and administering medications per physician order. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. As well as performing physician ordered monitoring and follow up per physician orders.	

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	495320	A. BUILDING _____ B. WING _____	12/15/2016

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F 309	Continued From page 9 #2 then called the contracting pharmacy in the presence of the surveyor. After this phone conversation LPN #2 verbalized to the surveyor that the pharmacy stated they did not have a script for this order. On 12/13/16 at approximately 4:00 p.m. the surveyor spoke with pharmacist #1 via phone. Pharmacist #1 verbalized to the surveyor that she was unable to locate an order to indicate the Resident was receiving 7.5/325 mg of norco. On 12/13/16 at approximately 4:12 p.m. LPN #2 approached the surveyor and stated she had spoken to the physician via phone and he had stated the order for the norco was supposed to be every 6 hours. A clarification order signed by the physician and dated 12/13/16 was provided to the surveyor that read "Clarification. Norco 7.5 mg/325 i (one) po q 6 hrs scheduled Dx (diagnosis) Chronic Pain." B). The clinical record included a telephone order dated 11/07/16 and signed by the physician to "D/C Cipro (antibiotic) 500 mg Begin Bactrim DS (double strength) PO QD (every day) X 7 days" and a nursing entry regarding the antibiotics that read "Received new order to DC Cipro...Start Bactrim DS PO BID X 7 days. RP (responsible party) and pharmacy notified." A review of the Resident #2's eMAR's for November 2016 indicated that the cipro had been discontinued on 11/07/16. However, the bactrim had not been started until 10/09/16 and was dosed everyday. This medication was available at the facility in the stat box for administration. When the bactrim was started the Resident received a total of 12 doses. If the order had been	F 309	**Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **January 29, 2017**	

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F 309	Continued From page 10 BID X 7 days the Resident should have received 14 doses if the order had been everyday the Resident should only have received 7 doses. On 12/15/16 at approximately 11:08 a.m. the surveyor spoke with pharmacist #2 via phone. Pharmacist #2 verbalized to the surveyor that the pharmacy had delivered 14 doses of the antibiotic to the facility on 11/08/16 and 1 dose had been removed from the stat box. The DON (director of nursing) was made aware of the conflicting information regarding the antibiotic on 12/15/16 at approximately 11:20 a.m. The administrative team (administrator, DON, and nurse consultant) was notified of the issues regarding the Residents pain medication and antibiotic therapy during a meeting with the survey team on 12/15/16 at 12:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #18 the facility staff failed to administer the Residents hypertensive medication metoprolol as ordered by the physician. The order was for twice a day the facility had administered the medication one time a day. The record review revealed that Resident #18 had been admitted to the facility 11/14/16. Diagnoses included, but were not limited to, diabetes, hypertension, depression, anxiety, and chronic pain. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 11	F 309		

with an ARD (assessment reference date) of 11/21/16 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

This was a closed record review.

The clinical record included the following.
Admission orders from the hospital that included orders for "metoprolol tartrate 25 mg tablet Directions: 1 tablet oral twice a day for hypertension."
Physician order summary signed by the physician on 11/15/16 that included the order "METOPROLOL TARTRATE 25 MG TAB 1 TABLET PO (by mouth) BID (twice a day) DX (diagnosis) HTN (hypertension)."

A review of Residents #18's eMAR's (electronic medication administration records) for November and December 2016 revealed that this medication had been administered only one time a day at 8:00 a.m. throughout the Residents stay at the facility.

The contracting pharmacist had completed a drug regimen review of the Residents medications in November. The surveyor was unable to locate any information to indicate the pharmacist had acted on or was aware of the medication error.

A random review of the Residents blood pressures was completed by the surveyor with no problems being identified.

The Resident was discharged from the facility on 12/04/16.

The DON (director of nursing) was notified of the

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F 309	Continued From page 12 issue regarding the Residents blood pressure medication on 12/15/16 at approximately 8:15 a.m. The administrative team (administrator, DON, and nurse consultant) was notified of the issues regarding the Residents blood pressure medication during a meeting with the survey team on 12/15/16 at 12:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #3 the facility staff failed to follow facility bowel protocol. Resident #3 was admitted to the facility on 06/14/06 and readmitted on 03/14/13. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, hemiplegia, seizure disorder, anxiety, depression, psychotic disorder, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and end stage renal disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/13/16 coded the Resident as 2 out of 15 in section C, cognitive patterns. The Resident's CCP (comprehensive care plan was reviewed and contained a plan for constipation which read in part "Problem Onset: 10/14/16 Constipation at times. Goal and target date: ...will have regular bowel movements and no signs of constipation over the next 90 days. Approaches: Administer medications as ordered." Resident #3's clinical record was reviewed on 12/14/16. It contained a "Bowel Report Roster" for	F 309		

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F 309	Continued From page 13 the months of October, November and December. The bowel movement roster indicated that Resident #3 had no bowel movements from 10/01-10/07/16, a total of 7 days, from 11/10-11/15/16, a total of 5 days and from 12/09-12/13/16, also a total of 5 days. The surveyor requested and was provided a copy of the facility bowel protocol which read in part "Procedure: The bowel protocol will be initiated on Day 3 of no Bowel Movement. The 'standing orders' for bowel protocol will be as follows: 1. Milk of Magnesia 1 oz every day PO (by mouth) prn (as needed) on day 3 of no bowel movement (BM). 2. Dulcolax Suppository 1 per rectum (PR) prn on day 4 of no bowel movement (BM). 3. Fleets enema 1 per rectum (PR) on day 5 of no bowel movement within 24 hours of initiation of above protocol." The surveyor could not locate any information that indicated the bowel protocol had been instituted. The concern of the bowel protocol not being followed was discussed with the administrative team on 12/14/16 at approximately 1630. No further information was provided prior to exit. 4. For Resident #12 the facility staff failed to administer prn (as needed) medication per physician's orders. Resident #12 was admitted to the facility on 10/17/16. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hyperlipidemia, Alzheimer's disease, anxiety,	F 309		

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F 309	Continued From page 14 depression, psychotic disorder, hypothyroidism, and gout. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/18/16 coded the Resident as 2 out of 15 in section C, cognitive status. This is a quarterly MDS. Resident #12's clinical record was reviewed on 12/15/16. It contained a signed POS (physician's order summary) which read in part "ALLOPURINOL 100 MG TABLET 1 po (by mouth) daily, AMLODIPINE BESYLATE 5 MG TAB 1 po daily, PLAVIX 75 MG 1 po daily, LEXAPRO 10 MG TABLET 1 po daily, ZETIA 10 MG TABLET 1 po daily, LORATIADINE 10 MG 1 po daily, PANTOPRAZOLE SOD DR 40 MG TAB 1 po daily, TORSEMIDE 20 MG Tablet 1 po daily, LISINOPRIL 5 MG TABLET ONE PO QD (every day), KLOR-CON30 MEQ ONE PO BID (twice daily), CALTRATE 600 + D TABLET GIVE ONE PO BID, FERROUS SULFATE 325 MG TABLET ONE PO BID, BUSPIRONE HCL 10 MG TABLET PO BID, FISH OIL + D SOFTGEL ONE PO TID (three times daily)". Resident #12's MAR (medication administration record) for December 2016 was reviewed and contained the following entries: "ALLOPURINOL 100 MG TABLET 1 po (by mouth) daily, AMLODIPINE BESYLATE 5 MG TAB 1 po daily, PLAVIX 75 MG 1 po daily, LEXAPRO 10 MG TABLET 1 po daily, ZETIA 10 MG TABLET 1 po daily, LORATIADINE 10 MG 1 po daily, PANTOPRAZOLE SOD DR 40 MG TAB 1 po daily, TORSEMIDE 20 MG Tablet 1 po daily, LISINOPRIL 5 MG TABLET ONE PO QD (every day), KLOR-CON30 MEQ ONE PO BID (twice daily), CALTRATE 600 + D TABLET GIVE ONE	F 309		

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F 309	Continued From page 15 PO BID, FERROUS SULFATE 325 MG TABLET ONE PO BID, BUSPIRONE HCL 10 MG TABLET PO BID, FISH OIL + D SOFTGEL ONE PO TID (three times daily).. These entries had been signed with "N" on 12/15/16, with notation in the comments section of the MAR for each medication which read in part "held.nausea". Resident #12's POS also contained an entry which read in part "ZOFRAN 4 MG TABLET ONE TABLET Q12 HOURS AS NEEDED DX (diagnosis) NAUSEA AND VOMITING". The Resident's MAR also contained the same entry, which had not been signed as having been administered. The surveyor spoke with LPN (licensed practical nurse) #3 on 12/15/16 at approximately 1035 regarding holding Resident #12's medications. Surveyor asked LPN #3 why she had held the meds and LPN #3 stated that Resident #12's meds were held because Resident had vomited and was nauseated. Surveyor asked LPN #3 if she had administered Resident #12's prn Zofran and LPN #3 stated that she had not. Surveyor then asked LPN #3 if she had notified the physician that the meds had been held, and she stated that she had not. Surveyor informed the DON of the meds being held and the prn not being administered during a meeting on 12/15/16 at approximately 1245. The RNC (regional nurse consultant) provided the surveyor with a copy of a nurse's noted on 12/15/16 at approximately 1410 which read in part "12/15/16 10:40 AM At 0915 Resident noted to be in another Resident room. Noted to have vomited x 1. Resident very talkative and in good	F 309		

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F 309	Continued From page 16 spirits at this time. States 'I feel better now I ain't sick now'. Sitting up in chair at this time. No distress noted. Has wheeled self through out hallway. MD notified at 1045. New order to give prn zofran and give medications 15 minutes later. RP (responsible party) aware...." No further information provided prior to exit. 5. For Resident #6 the facility staff failed to discontinue an order for Norco and begin the new order. The clinical record of Resident #6 was reviewed 12/13/16 and 12/15/16. Resident #6 was admitted to the facility 9/9/16 with diagnoses that included but not limited to Anemia, atrial fibrillation, high blood pressure, heart failure, gastroesophageal reflux disease (GERD), arthritis, bursitis, spondylosis of the cervical region, and anxiety. Resident #6's five day minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/8/15 assessed the resident to have a cognitive summary of 8 out of 15. She was also coded to understand and usually be understood. Resident #6 was care planned for pain and comfort related to her arthritis, bursitis and spondylosis of the cervical region. On 12/14/16, Resident #6's September medication administration record (MAR) was reviewed. The surveyor observed that the resident was ordered Norco 10-325 tablet one by mouth three times a day (Norco is a pain medication). With a discontinue date of 10/22/16. The director of nurses provided a copy of the prescription for the Norco that was faxed to the pharmacy on 9/28/16. The prescription read: "Norco 10/325 po tid (three times a day) for pain." Further review of the MAR revealed the	F 309		

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F 309	Continued From page 17 medication Norco had previously been ordered two times a day (BID). The discontinue order date was 9/28/16; however the order for Norco two times a day was continued until 10/14/16. Starting on 10/14/16 at 10:00 pm and on 10/15/16 the Resident began to receive the medication three times a day. On 12/15/16, at 2:30 pm the regional nurse consultant was shown the order for the Norco. The surveyor asked what happened with the order. He said "The order was not discontinued as ordered." On 12/15/16 prior to exit the administrator, director of nurses and the regional nurse consultant were informed of the medication error. No further information was provided by the facility related to the concern. 6. For Resident #14 the facility staff failed to follow physicians order in the administration of Florajen Bifidoblend a high potency probiotic. Resident #14 was admitted to the facility on 01/27/15 and was readmitted on 12/03/16. Diagnoses included but were not limited to, COPD (chronic obstructive pulmonary disease), CVA (cerebrovascular accident/stroke), hypertension, diabetes, anxiety, and arthritis. The most recent MDS (minimum data set) assessment completed on this Resident was a significant change in status assessment with an ARD (assessment reference date) of 12/10/16. Section C (cognitive patterns) of this assessment was coded (1/1/3) indicating the resident had problems with short term and long term memory and was severely impaired in cognitive skills for daily decision making. Review of Resident #14's clinical record revealed a physician's order for Florajen Bifidoblend	F 309		

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F 309	Continued From page 18 capsule one po (by mouth) QD (every day) x 7 days. The medication was ordered on 12/3/16 but not started until 12/4/16. The Florajen Bifidoblend was discontinued on 12/9/16. Resident #14 only received 6 days of the medication. On 12/14/16 the director of nurses was shown the medication error. After looking at the medication administration record she agreed that all 7 days of the medication had not been given as ordered. On 12/14/16 at 4:30 pm, the administrator, director of nurses and regional nurse consultant were informed of the failure of the staff to administer the medication as ordered. Prior to exit no further information was provided to the surveyor by the facility staff.	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	**F 329** **Corrective Action(s):** Resident #6's attending physician was notified that resident #6 was receiving both Omeprazole and Dexilant DR at the same time. Resident #6's attending physician reviewed resident #6's medication orders and discontinued the Dexilant DR order. A facility Incident & Accident form and a medication error form was completed for this incident.	

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F 329	Continued From page 19 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 20 residents (Resident #6) was free from an unnecessary medication. The findings include: The facility staff failed to accurately reconcile Resident #6 medications to ensure he did not receive two proton pump inhibitor medications. The clinical record of Resident #6 was reviewed 12/13/16 and 12/15/16. Resident #6 was admitted to the facility 9/9/16 with diagnoses that included but not limited to Anemia, atrial fibrillation, high blood pressure, heart failure, gastroesophageal reflux disease (GERD), arthritis and anxiety. Resident #6's five day minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/8/15 assessed the resident to have a cognitive summary of 8 out of 15. She was also coded to understand and usually be understood. On 12/14/16, Resident #6's December medication administration record (MAR) was reviewed. The surveyor observed that the	F 329	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving medications may have been potentially affected. The DON, ADON and/or Pharmacy consultant will review the medication orders of all residents to ensure that no unnecessary medications or duplicate medication therapy has been ordered. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of all medications. This includes verifying and reconciling all admission/readmission orders to ensure unnecessary or duplicate medications are not being ordered or administered.	

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HERITAGE HALL CLINTWOOD	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 20 resident was taking Dexilant DR 60 mg (proton pump inhibitor) by mouth daily. Also noted on the MAR was Omeprazole DR 20mg (proton pump inhibitor) by mouth daily. Review of the December physician orders revealed the Resident had orders for both medications. Further review of Resident #6 clinical record revealed documentation that Resident #6 was taking both of the proton pump inhibitor medications in the months of November and part of October 2016. There was no evidence that the nurses or the physician had reconciled the physician order summary (POS) and the MAR to ensure the Resident did not receive two proton pump inhibitors. Review of Resident #6's physicians progress note dated 10/31/16 revealed that the physician had documented: "GERD-stable, follow continue Dexilant." Review of the physician's progress dated 11/30/16 related to the GERD the physician's documentation read: "GERD-continue Omeprazole, follow." December's progress note dated 12/13/16 by the nurse practitioner read as follows: "GERD- Omeprazole 20mg, QD (every day)." On 12/14/16 the director of nurses was asked why resident #6 was on two proton pump medications. She responded, "I will need to look at the record and see why." At 11:20am, the surveyor contacted the pharmacist by telephone and asked him if Resident #6 should be on two different proton pump inhibitor medications. After he reviewed the Residents medication list he stated, When Resident #6 was discharged from the hospital	F 329	**Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or designee will complete weekly physician orders and MAR audits coinciding with the Care plan calendar to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **January 29, 2017**	

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F 329	Continued From page 21 only the Dexilant was ordered, we don't have a current order for the Omeprazole DR 20mg. At 11:55am the director of nurses informed the surveyor she had contacted the physician and he said he thought the resident was only on the Dexilant and wanted to review the record and would call back. The surveyor asked to speak with the physician when he called back, however this did not occur. On 12/14/16 at 4:30 pm, the administrator, director of nurses and regional nurse consultant were informed of the failure of the staff and care team to reconcile the Resident's medication. On 12/15/16 the director of nurses informed the survey team that the physician wanted the resident on the Omeprazole. Review of the facility policy and procedure titled Reconciliation of Medications on Admission Read as follows under general guidelines: "4. Medication reconciliation helps to ensure that medications, routes and dosages have been accurately communicated to the attending physician and care team. Under steps and procedures 5. Review the list carefully to determine if there are discrepancies/conflicts. " On 12/15/16 prior to exit no further information was provided by the facility.	F 329		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		

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F 333	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure 4 of 20 Residents were free of significant medication errors involving insulin. Residents #9, #14, #3, and #8. The findings included. 1. For Resident #9, the facility staff administered 10 units of humalog insulin a total of 24 times in November and December 2016 without a physicians order. The record review revealed that Resident #9 had been admitted to the facility 04/22/16. Diagnoses included, but were not limited to, diabetes, long term use of insulin, kidney failure, chronic kidney disease, and dementia. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/20/16 was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. The Residents clinical record included a physician signed (11/03/16) POS (physician order summary) that included an order for "HUMALOG...PER SLIDING SCALE COVERAGE 0-150=0 UNITS, 151-200=2 UNITS, 201-250=4 UNITS, 251-300=6 UNITS, 301-350=8 UNITS." This insulin was administered daily before meals using the sliding scale as ordered by the physician.	F 333	**F333** **Corrective Action(s):** Resident #9's attending physician has been notified that the facility failed to administer Humalog Sliding scale insulin per physician order. The nurse involved in entering the initial one time insulin order incorrectly has received one-on-one inservice training from the DON on the administration of physician ordered medications. A facility Medication error form was completed for each incident. Resident #14's attending physician has been notified that the facility failed to administer Lantus insulin per physician order. LPN #3 involved in holding the insulin incorrectly has received one-on-one inservice training from the DON on the administration of physician ordered medications. A facility Medication error form was completed for each incident Resident #3's attending physician has been notified that the facility staff did not administer insulin per physician order and held resident #3's insulin without notifying the attending physician. Resident #3's physician order insulin has been reviewed to ensure all medication orders are accurate. A Facility Incident & Accident Form was completed for these incidents.	

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F 333	Continued From page 23 A review of Resident #9's eMAR's (electronic medication administration records) for November and December 2016 revealed that for the month of November the facility nursing staff administered 10 units of humalog insulin 18 times and from December 1-13 the facility nursing staff had administered 10 units of humalog insulin 6 times. The contracting pharmacist had completed a drug regimen review for this Resident on 11/2_/2016 and no irregularities regarding the insulin were reported. After reviewing the clinical record the clinical nurse consultant verbalized to the surveyor that it appeared that there had been a one-time order for 10 units of insulin at some point and whoever had placed the order into the computer system had put the order in incorrectly. The facility policy/procedure titled "Adverse consequences and Medication Errors" read in part-"...A "medication error" is defined as the preparation or administration of drugs or biological which is not in accordance with the physician's orders..." The administrative staff, administrator, AIT (administrator in training), DON (director of nursing), and nurse consultant, were notified of the significant medication errors involving insulin and Resident #9 during a meeting with the survey team on 12/14/16 at approximately 4:30 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 333	Resident #8's attending physician has been notified that the facility failed to administer Novolin R Sliding scale insulin per physician order. The nurse that did not administer the Novolin R insulin per physician order has received one-on-one inservice training from the DON on the administration of physician ordered medications. A facility Medication error form was completed for each incident **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving Physician ordered Insulin may have potentially been affected. A 100% review of all residents with insulin orders will be conducted to identify residents at risk. All residents identified at risk will be corrected at time of discovery and appropriate disciplinary action taken. An Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced on the facility policy and procedure by the DON regarding the administration of medications per physician orders to include the proper administration of insulin to include sliding scale insulin as ordered by the physician.	

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F 333	Continued From page 24 2. For Resident #14 the facility staff failed to ensure insulin was given as ordered by the physician to prevent a significant medication error. Resident #14 was admitted to the facility on 01/27/15 and was readmitted on 12/03/16. Diagnoses included but were not limited to, COPD (chronic obstructive pulmonary disease), CVA (cerebrovascular accident/stroke), hypertension, diabetes, anxiety, and arthritis. The most recent MDS (minimum data set) assessment completed on this resident was a significant change in status assessment with an ARD (assessment reference date) of 12/10/16. Section C (cognitive patterns) of this assessment was coded (1/1/3) indicating the resident had problems with short term and long term memory and was severely impaired in cognitive skills for daily decision making. Clinical record review on 12/15/16, revealed that Lantus insulin 24 units every day was not documented as administered on the medication administration record (MAR) at 6:30 AM on 12/9/16, 12/10/16 ,12/12/16 ,12/13/16 ,and 12/15 2016. The explanation for the omission in the nurse's notes was "special requirement not met." The surveyor could not find in the clinical record a corresponding order for a special requirement or parameters to hold the medication. On 12/15/16, LPN #3 was asked why she did not administer the Lantus insulin; she said "the computer blocked me giving it because of the parameters. She was asked if there was an order for the parameters she responded, "Some put in parameters without an order. I did not call the	F 333	**Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will do weekly MAR audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **January 29, 2017**	

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F 333	Continued From page 25 physician because of the parameter." The director of nurses was shown the MAR and asked why the insulin was not given. Her response was "there was no reason to hold the Lantus." The concern was reported to administrative staff during a summary meeting on 12/15/16 at 12:45 p m. No further information was provided prior to the exit conference on 12/15/16. 3. For Resident #3 the facility held the insulin Toujeo without a physician's order. Toujeo is a long-acting insulin used to treat diabetes. Resident #3 was admitted to the facility on 06/14/06 and readmitted on 03/14/13. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, hemiplegia, seizure disorder, anxiety, depression, psychotic disorder, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and end stage renal disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/13/16 coded the Resident as 2 out of 15 in section C, cognitive patterns. Resident #3's clinical record was reviewed on 12/14/16. It contained a signed POS (physician's order summary) dated 12/13/16 which read in part "TOUJEO SOLOSTAR 300 UNITS/ML GIVE 45ML SUBCUTANIOUS QAM (every morning) DX (diagnoses) DM TYPE II Generic: INSULIN GLARGINE, HUMAN RECOMBINANT ALALOG". The start date for this order was listed as	F 333		

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F 333	Continued From page 26 08/29/16. The Resident's MAR's (medication administration record) for the months of October, November and December 2016 were reviewed and contained an entry which read in part "TOUJEO SOLOSTAR 300 UNITS/ML GIVE 45ML SUBCUTANIOUS QAM DX (diagnoses) DM TYPE II". For the month of October, the MAR had been signed with "N" on the following dates: 10/01-10/03, 10/05, 10/11, 10/15-10/16, 10/24, 10/28, and 10/31. For November, the MAR had been signed with "N" on the following days: 11/04-11/08, 11/10-11/12, 11/14, 11/16, 11/18-11/19, 11/21-11/25, and 11/28-11/29. For the month of December the MAR had been signed with "N" for 12/01-12/02, 12/05-12/06, 12/08-12/09, 12/11, and 12/14. The comments section of the MAR on the days signed with "N" read in part "TOUJEO SOLOSTAR 300UNITS/ML GIVE 45ML S... scheduled for ...was held.special requirement not met". The surveyor could not locate any physician's order to hold the Toujeo insulin or any nurse's notes stating the physician had been notified when the Toujeo had been held. The surveyor spoke with RN (registered nurse) #1 on 12/14/16 at approximately 1615 regarding Resident #3's insulin being held. RN #1 stated that the Resident's daughter did not want the Toujeo insulin given if Resident's blood sugar levels are below a certain level. Surveyor asked RN #1 below what level did the daughter want the Toujeo held, and RN #1 answered 150-170. The surveyor spoke with LPN (licensed practical nurse) #3, who is Resident #3's daughter on 12/15/16 at approximately 1030 regarding holding the Toujeo. Surveyor asked LPN #3 why she	F 333		

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F 333	Continued From page 27 requested her mother's insulin be held and she stated "She bottomed out on me one day and I just feel better about holding it". Surveyor then asked LPN #3 if she had discussed this with Resident #3's physician, and she stated that she had not. The concern of holding the insulin was discussed with the administrative team on 12/14/16 at approximately 1630. The DON (director of nursing) provided the surveyor with a copy of "Administering Medications" policy on 12/15/16 at approximately 0800, which read as follows: Policy Statement Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 3. Medications must be administered in accordance with the orders, including any required time frame. The surveyor was also provided with a copy of "Adverse Consequences and Medication Errors " which read as follows: Policy Interpretation and Implementation 5. A "medication error" is defined as the preparation of administration of drugs or biological which is not in accordance with physician's orders, manufacturer specification, or accepted professional standards and principles of the professional(s) providing these services. 6. Examples of medication errors include: a. Omission-a drug is ordered but not administered.	F 333		

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F 333	Continued From page 28 No further information was provided prior to exit. 4. For Resident #8 the facility staff failed to administer the insulin Novolin R within the physician ordered parameters. Novolin R is a short-acting insulin used to treat diabetes. Resident #8 was admitted to the facility on 12/27/16 and readmitted on 01/22/15. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, diabetes mellitus, hyperlipidemia, cerebrovascular accident, dementia, Parkinson's disease, anxiety, depression, psychotic disorder, chronic obstructive pulmonary disease, chronic kidney disease, constipation and dysphagia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/12/16 coded the Resident as 11 out of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #8's clinical record was reviewed on 12/14/16. It contained a signed POS (physician's order summary) which read in part "NOVOLIN R 100 UNITS/ML VIAL via SLIDING SCALE INSULIN FSBS (finger stick blood sugar) AC (before meals) 0-60=0 UNITS, 61-150=0 UNITS, 151-200=2 U, 201-250=4 U, 251-300=6U, 301-350=8U, 351-400=10U, 401-999=12U NOTIFY MD". Resident #8's MAR's (medication administration record) for the months of November and December were reviewed and contained an entry which read in part "NOVOLIN R 100 UNITS/ML VIAL via SLIDING SCALE INSULIN FSBS (finger	F 333		

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F 333	Continued From page 29 stick blood sugar) AC (before meals) 0-60=0 UNITS, 61-150=0 UNITS, 151-200=2 U, 201-250=4 U, 251-300=6U, 301-350=8U, 351-400=10U, 401-999=12U NOTIFY MD". On 11/17/16 at 4:30pm, the MAR had been signed "N" with a comment which read in part "NOVOLINR ...scheduled for 11/17/16 4:30 PM was held.special requirement not met. Pre Admin Blood Glucose: 193." The concern of holding the insulin outside of physician ordered parameters was discussed during meeting with the administrative staff on 12/15/16 at approximately 1245. No further information was provided prior to exit.	F 333		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to identify and report medication irregularities for 4 of 20 Residents, Resident #3, Resident #6, Resident #9 and Resident #18.	F 428	**F428** **Corrective Action(s):** Resident #3 has been re-assessed by the attending physician and the consulting pharmacist for the accurate dose and administration of Toujeo Solostar. Resident #3's physician ordered Toujeo Solostar has been clarified and the comprehensive care plans has been revised to reflect approaches and interventions to meet the resident's current needs. Resident #6 has been re-assessed by the attending physician and the consulting pharmacist for the use of proton-pump inhibitor. Resident #6's physician orders have been clarified and the Dexilant DR has been discontinued and the Omeprazole order has been clarified and the comprehensive care plans has been revised to reflect approaches and interventions to meet the resident's current needs.	

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F 428	Continued From page 30 The findings included: For Resident #3 the facility staff failed to identify and report an error on the POS (physician's order summary) and MAR (medication administration record) for the dosage of the long acting insulin, Toujeo. Resident #3 was admitted to the facility on 06/14/06 and readmitted on 03/14/13. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, hemiplegia, seizure disorder, anxiety, depression, psychotic disorder, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and end stage renal disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/13/16 coded the Resident as 2 out of 15 in section C, cognitive patterns. Resident #3's clinical record was reviewed on 12/14/16. It contained a signed POS (physician's order summary) dated 12/13/16 which read in part "TOUJEO SOLOSTAR 300 UNITS/ML GIVE 45ML SUBCUTANIOUS QAM (every morning) DX (diagnoses) DM TYPE II Generic: INSULIN GLARGINE, HUMAN RECOMBINANT ALALOG". The Resident's MAR's (medication administration record) for the months of October, November and December 2016 were reviewed and contained an entry which read in part "TOUJEO SOLOSTAR 300 UNITS/ML GIVE 45ML SUBCUTANIOUS QAM DX (diagnoses) DM TYPE II". The surveyor spoke with pharmacist #3 on	F 428	Resident #9 has been re-assessed by the attending physician and the consulting pharmacist and the Humolog sliding scale insulin orders have been reviewed. Resident #9's physician ordered Humolog Sliding Scale insulin has been clarified and the comprehensive care plans has been revised to reflect approaches and interventions to meet the resident's current needs. Resident #18 is no longer in the facility. Resident #18's attending physician was made aware of the medication error. A facility Medication Error report has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents receiving multiple medications (9 or more) may have been potentially affected. The pharmacy consultant will conduct a 100% review of all current resident's medication regimens to identify residents in need of pharmacy recommendations, follow up, and review. Any/all negative findings will be corrected at time of discovery. A Risk Management Incident/Accident form will be completed for each incident identified.	

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F 428	Continued From page 31 12/14/16 at approximately 1115. Surveyor asked pharmacist #3 what the correct dosage of Toujeo insulin should be for Resident #3 and pharmacist stated the correct order should read "Toujeo 300u/ml give 45 units" rather than 45ml. Resident #3's clinical record contained a "Medication Regimen Review" form for the months of April-December 2016. The consulting pharmacist had initialed and dated the form for all months and checked the box labeled "NI*". The asterisk (*) was defined at the bottom of the form as "Based on the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the Resident's medication regimen contained no new irregularities (as defined in SOM Appendix PP 483.60(c)). For purpose of the foregoing statement, the term "irregularity" means an event or circumstance that is substantially inconsistent with customary, accepted clinical approaches to providing pharmaceutical product and services, or that could reasonably be expected to impede or interfere with the achievement of intended or reasonably expected outcomes." The concern of the discrepancy in the physician's order and MAR for Toujeo was discussed during a meeting with administrative staff on 12/14/16 at approximately 1630. No further information was provided prior to exit. 2. The consulting pharmacist failed to accurately reconcile Resident #6 medications and report to the physician to ensure he did not receive two proton pump inhibitor medications.	F 428	**Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The consultant pharmacist will review all resident's medication regime monthly to address appropriate use, reduction, and elimination if needed. All licensed nursing staff will be inserviced by the DON on the importance of monitoring medication regimens for medication reduction and elimination as recommended by the Consulting Pharmacist. The DON and/or ADON will review all pharmacy recommendations monthly to ensure that any/all pharmacy recommendations have been addressed and proper notification to attending physicians has been completed. **Monitoring:** The DON is responsible for maintaining compliance. The DON, and/or designee will perform monthly audits of the pharmacy recommendations to ensure that the recommendations are being completed and followed up on timely. Any/all negative findings will be corrected at time of discovery. Detail findings of this review will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **January 29, 2017**	

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F 428	Continued From page 32 The clinical record of Resident #6 was reviewed 12/13/16 and 12/15/16. Resident #6 was admitted to the facility 9/9/16 with diagnoses that included but not limited to Anemia, atrial fibrillation, high blood pressure, heart failure, gastroesophageal reflux disease (GERD), arthritis and anxiety. Resident #6's five day minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/8/15 assessed the resident to have a cognitive summary of 8 out of 15. She was also coded to understand and usually be understood. On 12/14/16, Resident #6's December medication administration record (MAR) was reviewed. The surveyor observed that the resident was taking Dexilant DR 60 mg (proton pump inhibitor) by mouth daily. Also noted on the MAR was Omeprazole DR 20mg (proton pump inhibitor) by mouth daily. Review of the December physician orders revealed the resident had orders for both medications. Further review of Resident #6 clinical record revealed documentation that Resident #6 was taking both of the proton pump inhibitor medications in the months of November and part of October 2016. There was no evidence that the pharmacist, nurses or the physician had reconciled the POS and the MAR to ensure the Resident did not receive two proton pump inhibitors. The pharmacy medication regimen review form was documented for October and November of 2016. The pharmacist signed and dated the form that the review was done but there was no other documentation for October. There was a note	F 428		

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F 428	Continued From page 33 made for November that the Resident was in the hospital. The clinical record did not reveal any documentation that indicated the pharmacist had reported the irregularity to the physician. At 11:20am, the surveyor contacted the pharmacist by telephone and asked him if Resident #6 should be on two different proton pump inhibitor medications. After he reviewed the Residents medication list he stated, When Resident #6 was discharged from the hospital only the Dexilant was ordered, we don't have a current order for the Omeprazole DR 20mg. At 11:55am the director of nurses informed the surveyor she had contacted the physician and he said he thought the resident was only on the Dexilant and wanted to review the record and would call back. The surveyor asks to speak with the physician when he called back, however this did not occur. On 12/14/16 at 4:30 pm, the administrator, director of nurses and regional nurse consultant were informed of the failure of the staff and care team to reconcile the Resident's medication. On 12/15/16 the director of nurses informed the survey team that the physician wanted the Resident on the Omeprazole only. On 11/15/16 prior to exit no further information was provided by the facility. 3. For Resident #9, the contracting pharmacist failed to identify and report irregularities regarding the Resident's sliding scale humalog insulin to the facility. The record review revealed that Resident #9 had	F 428		

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F 428	Continued From page 34	F 428		

been admitted to the facility 04/22/16. Diagnoses included, but were not limited to, diabetes, long term use of insulin, kidney failure, chronic kidney disease, and dementia.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/20/16 was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making.

The Residents clinical record included a physician signed (11/03/16) POS (physician order summary) that included an order for "HUMALOG...PER SLIDING SCALE COVERAGE 0-150=0 UNITS, 151-200=2 UNITS, 201-250=4 UNITS, 251-300=6 UNITS, 301-350=8 UNITS." This insulin was administered daily before meals using the sliding scale as ordered by the physician.

A review of the Resident's eMAR's (electronic medication administration records) was completed for November and December 2016. This review revealed that for the month of November the facility nursing staff administered 10 units of humalog insulin 18 times and from December 1-13 the facility nursing staff had administered 10 units of humalog insulin 6 times.

The contracting pharmacist had completed a drug regimen review for this Resident on 11/2_/2016 and no irregularities regarding the insulin were reported. In fact the pharmacist had checked the corresponding box "NI*." Per the preprinted code on the bottom of the form titled "MEDICATION REGIMEN REVIEW" NI was defined as "Based

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F 428	Continued From page 35 on the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the Resident's medication regimen contained no new irregularities (as defined in SOM Appendix PP 483.60(c)). For purpose of the foregoing statement, the term "irregularity" means an event or circumstance that is substantially inconsistent with customary, accepted clinical approaches to providing pharmaceutical product and services, or that could reasonably be expected to impede or interfere with the achievement of intended or reasonably expected outcomes." After reviewing the clinical record the clinical nurse consultant verbalized to the surveyor that it appeared that there had been a one-time order for 10 units of insulin at some point and whoever had placed the order into the computer system had put the order in incorrectly. The facility policy/procedure titled "Adverse consequences and Medication Errors" read in part-"...A "medication error" is defined as the preparation or administration of drugs or biological which is not in accordance with the physician's orders..." The administrative staff (administrator, DON (director of nursing), and nurse consultant) were notified of the above in meeting with the survey team on 12/15/16 at approximately 12:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #18, the contracting pharmacist	F 428		

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F 428	Continued From page 36 failed to identify and report irregularities regarding the Resident's blood pressure medication to the facility. The record review revealed that Resident #18 had been admitted to the facility 11/14/16. Diagnoses included, but were not limited to, diabetes, hypertension, depression, anxiety, and chronic pain. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/21/16 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The clinical record included the following. Admission orders from the hospital that included orders for "metoprolol tartrate 25 mg tablet Directions: 1 tablet oral twice a day for hypertension." Physician order summary signed by the physician on 11/15/16 that included the order "METOPROLOL TARTRATE 25 MG TAB 1 TABLET PO (by mouth) BID (twice a day) DX (diagnosis) HTN (hypertension)." A review of the Residents eMAR's (electronic medication administration records) for November and December 2016 revealed that this medication had been administered only one time a day at 8:00 a.m. throughout the Residents stay at the facility. The contracting pharmacist had completed a drug regimen review of the Residents medications in November (11/18/16). The surveyor was unable to locate any information to indicate the	F 428		

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F 428	Continued From page 37 pharmacist had acted on or was aware of the medication error. The pharmacist had checked the corresponding box on the "MEDICATION REGIMEN REVIEW" form that read "See report for any noted irregularities and/or recommendations." However, a copy of this report was not shared or provided to the surveyor. A random review of the Residents blood pressures was completed by the surveyor with no problems being identified. The Resident was discharged from the facility on 12/04/16. The DON (director of nursing) was notified of the issue regarding the Residents blood pressure medication on 12/15/16 at approximately 8:15 a.m. The administrative team (administrator, DON, and nurse consultant) was notified of the issues regarding the Residents blood pressure medication during a meeting with the survey team on 12/15/16 at 12:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	**F441** **Corrective Action(s):** LPN #2 involved in the Medication Pass for Resident #1 has been inserviced one-on-one on proper hand washing and infection control practices during medication administration pass. A Facility Incident & Accident form was completed for this incident.	

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F 441	Continued From page 38 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and during a medication pass and pour observation the facility staff failed to follow established infection control guidelines in regards to hand hygiene on 1 of 2 units (right side).	F 441	**Identification of Deficient Practice(s) & Corrective Action(s):** All residents may have the potential to be affected by improper hand washing and infection control techniques. The DON and/or ADON will conduct medication pass audits on all licensed staff to observe proper infection control practices and proper hand washing during medication administration procedures. Any negative findings will be addressed immediately and disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no changes are warranted at this time. All licensed staff will be inserviced on the facility policy and procedure for proper hand washing and the infection control policy and procedure by the DON and/or Regional Nurse Consultant. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or designee will perform 2 random weekly Medication Pass audits to monitor nursing staff for compliance. Findings of the audits will be reported to the QA Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** January 29, 2017	

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F 441	Continued From page 39 The findings included. The facility nursing staff failed to complete hand hygiene during a medication pass and pour observation. On 12/14/16 beginning at approximately 7:55 a.m. the surveyor observed LPN (licensed practical nurse) #2 prepare and administer medications on the right side. After administering medications to unsampled Resident #1 LPN #2 returned to the medication cart in the hallway, removed her gloves, signed for the medications she had administered, and then began setting up medications for the next Resident. After watching LPN #2 for several minutes the surveyor asked LPN #2 about washing her hands or performing hand hygiene after removing her gloves. LPN #2 verbalized to the surveyor that she had not washed her hands but she would now. The administrative staff (administrator, DON (director of nursing), AIT (administrator in training), and nurse consultant) were notified that LPN #2 failed to complete hand hygiene after removing her gloves during a meeting with the survey team on 12/14/16 at approximately 4:30 p.m. On 12/14/16 at approximately 4:50 p.m. the surveyor interviewed the designated infection control nurse. When asked about handwashing/hand hygiene after removing gloves the infection control nurse verbalized to the surveyor that she would have expected the nurse to wash her hands after removing her gloves.	F 441		

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F 441	Continued From page 40 The facility policy/procedure titled "Handwashing/Hand Hygiene" read in part "This facility considers hand hygiene the primary means to prevent the spread of infections...Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively soap (antimicrobial or non-antimicrobial) and water for the following situations...After removing gloves...Hand hygiene is the final step after removing and disposing of personal protective equipment." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to obtain a physician ordered lab for 1 of 20 Residents, Resident #8. The findings included: For Resident #8 the facility staff failed to obtain the physician ordered lab, Chem 13 level for the months of August and October 2016. Resident #8 was admitted to the facility on 12/27/16 and readmitted on 01/22/15. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, diabetes mellitus,	F 502	**F502** **Corrective Action(s):** Resident #8's attending physician has been notified that the facility failed to obtain a Chem 13 lab test as ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who had physician ordered lab tests may have potentially been affected. A 100% audit of all resident's lab orders will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. The attending physicians will be notified of the missing labs, labs not obtained timely and labs obtained without a physician order. A facility Incident & Accident Form will be completed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 502	Continued From page 41 hyperlipidemia, cerebrovascular accident, dementia, Parkinson's disease, anxiety, depression, psychotic disorder, chronic obstructive pulmonary disease, chronic kidney disease, constipation and dysphagia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/12/16 coded the Resident as 11 out of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #8's clinical record was reviewed on 12/14/16. It contained a signed POS (physician's order summary) which read in part "CHEM 13 LEVEL Q (every) MONTH". The surveyor could not locate the results of the Chem 13 level for the months of August 2016 and October 2016. The surveyor asked the DON (director of nursing) is she could locate the missing labs and she could not. The concern of the missing labs was discussed during a meeting with the administrative team on 12/15/16 at approximately 1245. No further information was provided prior to exit.	F 502	**Systemic Changes:** The facility policy and procedure has been reviewed and no changes are warranted at this time. The laboratory tracking system has been reviewed and implemented to track and validate that required lab work has been completed per physician order and policy and procedure. The DON and/or Nurse Consultant will inservice all licensed staff on physician ordered laboratory-testing, protocols, & tracking system used. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will complete the Facility Lab audit tool weekly to monitor for compliance. Any negative findings will be reported to the attending physician and disciplinary action will be taken as warranted. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **January 29, 2017**	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		

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F 514	Continued From page 42 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 3 out of 20 Resident's (Residents # 5, # 3 and # 7). The findings included. 1. The facility staff failed to maintain accurate documentation to indicate that facility staff clarified a laboratory test BMP (basic metabolic panel) Resident #5's. Resident #5 was admitted to the facility 11/18/05 and readmitted on 8/24/16 with diagnoses that included but not limited to dementia, high blood pressure, heart failure, seizure disorder, and esophageal reflux disorder. A review of Resident #5's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date (ARD) of 11/29/16, the facility staff assessed the Resident to understand and to be understood. She was assessed to have a cognitive summary score of 15. On 12/13/16 a review of Resident #5's clinical record revealed a physician's order for a BMP in 3 days, dated 11/15/16. The record also revealed an order for a CMP (comprehensive metabolic panel) with an order date of 11/15/16. The BMP laboratory test is part of the CMP test.	F 514	**F514** **Corrective Action(s):** Resident #5's attending physician has been notified that the facility staff failed to ensure that physician ordered BMP laboratory results were in the clinical record. A facility incident and accident form has been completed for this incident. Resident #3's attending physician has been notified that the facility staff failed to transcribe a physician ordered insulin order accurately. A facility incident and accident form has been completed for this incident. Resident #7's attending physician has been notified that the facility staff failed to accurately document antibiotic administration on the MAR. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all resident medical records will be conducted by the DON, ADON and/or Medical Records clerk to identify residents at risk for an inaccurate medical record and illegible documentation. All negative findings will be clarified and/or corrected at time of discovery and the attending physician notified of the incident. A facility Incident & Accident form will be completed for each negative finding.	

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F 514	Continued From page 43 The clinical record also revealed that a CMP was obtained on 11/16/16; however there was no BMP test found in the clinical record. On 11/13/16 LPN #4 told the surveyor that the order was received on the 14th and counting the order day the lab was due on the 16th. She said she had written the order date incorrectly. On 11/14/16 the director of nurse said, "We didn't want to stick Resident #5 twice so we obtained the CMP. The BMP is part of the CMP. " On 11/14/16 at 4:30 pm during an end of the day meeting the surveyor informed the administrator and director of nurses of the failure to clarify the order for the BMP. Prior to exit no further exit was provided to the surveyor. 2. For Resident #3 the facility staff failed to ensure an accurate POS (physician's order summary) and MAR (medication administration record). Resident #3 was admitted to the facility on 06/14/06 and readmitted on 03/14/13. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, hemiplegia, seizure disorder, anxiety, depression, psychotic disorder, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and end stage renal disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/13/16 coded the Resident as 2 out of 15 in section C,	F 514	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff and Medical Records clerk will be inserviced by the DON or regional nurse consultant on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include accurate documentation of medical information in the appropriate medical record and maintaining legible physician orders according to the acceptable professional standards and practices. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or designee will audit medical records, MAR's, TAR's, ADL records and care plans weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **January 29, 2017**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495320	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 44 cognitive patterns. Resident #3's clinical record was reviewed on 12/14/16. It contained a signed POS (physician's order summary) dated 12/13/16 which read in part "TOUJEO SOLOSTAR 300 UNITS/ML GIVE 45ML SUBCUTANIOUS QAM (every morning) DX (diagnoses) DM TYPE II Generic: INSULIN GLARGINE, HUMAN RECOMBINANT ALALOG". The Resident's MAR's (medication administration record) for the months of October, November and December 2016 were reviewed and contained an entry which read in part "TOUJEO SOLOSTAR 300 UNITS/ML GIVE 45ML SUBCUTANIOUS QAM DX (diagnoses) DM TYPE II". Surveyor spoke with pharmacist #3 on 12/14/16 at approximately 1115 regarding Resident #3's Toujeo order. Pharmacist stated the order should read 45 units, rather than 45ml. The surveyor requested a copy of the original physician's order for Toujeo from the DON (director of nursing). DON provided the order, dated 08/29/16, on 12/14/16 at approximately 1300. The order read in part "Toujeo Solostar 300 units/ml Give 45 units Sub Q (subcutaneously) QAM (every morning)". Surveyor spoke with RN (registered nurse) #1 on 12/14/16 at approximately 1616 regarding Resident #3's Toujeo. Surveyor asked RN #1 how much Toujeo she administered, and RN #1 stated that she did not know, because she had never given it. Surveyor then showed RN #1 the POS and asked her to read it back to surveyor. RN #1 looked at the POS and stated "Oh! that's not right".	F 514		

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F 514	Continued From page 45	F 514		

The concern of the incorrect POS and MAR were discussed with the administrative staff during a meeting on 12/14/16 at approximately 1630.

No further information was provided prior to exit.
3. For Resident #7, the facility staff failed to accurately document how many doses of the antibiotic bactrim had been administered.

The record review revealed that Resident #7 had been admitted to the facility 11/11/14. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, muscle weakness, and hypertension.

Section C (cognitive patterns) of the Resident's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/30/16 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points.

The clinical record included a physicians telephone order dated 12/01/16 for "Bactrim DS (double strength) i (one) BID (twice a day) X 7 days Dx (diagnosis) Cyst on Chest Wall."

A review of the Residents eMAR (electronic medication administration record) indicated that the facility nursing staff had documented that they had administered this medication from 12/01/16 at 8:00 p.m. until 12/09/16 at 8:00 p.m. for a total of 17 doses.

On 12/14/16 at approximately 3:30 p.m. the surveyor spoke with pharmacist #1 via phone. Pharmacist #1 verbalized to the surveyor that 14 doses of bactrim had been sent to the facility on 12/01/16. When asked if anything had been taken

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	Continued From page 46 from the stat box at the facility for this Resident pharmacist #1 stated she had nothing billed as of yet for this Resident regarding this medication being pulled from the stat box for administration. The administrative staff (administrator, AIT (administrator in training), DON (director of nursing), and nurse consultant) were notified of the incorrect documentation regarding the antibiotic bactrim and Resident #7 during a meeting with the survey team on 12/14/16 at approximately 4:30 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 514		