Our Home, Our Family, Our Life, Too.

Heritage Hall of Grundy • 2966 Slate Creek Road • Grundy, VA 24614 • (P) 276.935.8144

January 29, 2016

Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Rodney Miller, Long Term Care Supervisor
Richmond, VA 23233

Mr. Miller;

Attached to this cover letter you will find Heritage Hall – Grundy'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 the annual survey process.

Heritage Hall – Grundy is committed to providing high quality patient care. We appreciate your assistant in this matter.

If I can be of further assistance don't hesitate to contact me at (276) 935-8144.

Sincerely;

Derrick Ratliff
Administrator

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	495259	A. BUILDING _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/11/16 through 01/13/16. 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 120 certified bed facility was 112 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through #20) and 6 closed record reviews (Residents #21 through #26).	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review and employee record review it was determined the facility staff failed to implement the facility abuse policy to screen and verify licensure records for 2 of 20 newly hired employees. Findings: Facility staff failed to screen/verify 2 new hires for licensure requirements per facility policy. The facility abuse prohibition policy contained the following requirement for new employee screening: "....Careful screening of all employees,	F 226	**F226** **Corrective Action(s):** The RN and the LPN identified in the employee file review have had her LPN license verified with the Department of Health Professions and the printed copy was placed in her employee file. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other licensed employee's may be potentially affected. The Business Office Manager and/or designee will audit 100% of all active licensed employee records to identify employees at risk. Any/all negative findings will be corrected at the time of discovery. A Facility Incident & Accident form will be completed for any/all negative findings. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. Human Resources Staff will be inserviced and issued a copy of the policy & procedure by the Administrator on requirements for all licensed staff prior to employment and license or certification renewal.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 1-29-16

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 226	Continued From page 1 physicians, and contracted professionals.....License verification performed for all new employees prior to employment...." On 1/13/16 at 12:30 PM the survey team reviewed 20 staff records for employees hired since the last survey. The surveyors found two records (one registered nurse and one licensed practical nurse) that did not contain verification of professional nursing licenses prior to the employment date. The registered nurse was hired on 6/22/15 and the license verification was obtained on 1/11/16. The licensed practical nurse was hired on 11/17/15 and the license was verified on 1/11/16. The DON was informed of these observations on 1/13/16 at 1:00 PM. She said the licensure verifications were to be done on their hire date by either herself, her assistant or the business office staff. She did not provide further information prior to the survey team exit.	F 226	**Monitoring:** The Humans Resources manager is responsible for maintaining compliance. The Human Resources Manager and/or designee will conduct monthly audits of employee files to maintain compliance. The administrator will review all audits and report aggregate findings to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: 2-19-16**	
F 309 SS=D	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 and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 309	**F309** **Corrective Action(s):** Resident #2's attending physician was notified that the facility failed to apply Bactroban to nares per physician order. A facility Incident and Accident form was completed for this incident. Resident #20's attending physician was notified that the facility staff failed to administer Albuterol/Atrovent nebulizer treatments per physician order. A facility Incident and Accident form was completed for this incident.	

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F 309	Continued From page 2 review it was determined the facility staff failed to follow physician orders for 3 of 26 residents in the survey sample, (Residents #2, 20, and 1). 1. Facility staff failed to follow physician orders for Bactroban* administration for Resident #2. 2. Failed to follow orders for Albuterol/Atrovent** administration for Resident #20. 3. Failed to follow orders for medication administration re: blood pressure parameters for Resident #1. Findings: 1. Facility staff failed to follow physician orders for Bactroban administration for Resident #2. The resident's clinical record was reviewed on 1/12/16 at 8:30 AM. Resident #2 was admitted on 8/15/18. The current diagnoses included MRSA (methicillin resistant staph aureus), congestive heart failure, hypertension, and diabetes. The latest MDS (minimum data set) assessment, dated 11/24/15, coded the resident with mild cognitive impairment. The resident was coded as needing nursing staff assistance for all the ADLS (activities of daily living.) The current CCP (comprehensive care plan) updated on 12/16/15 did not contain the MRSA infection or isolation precautions as the problem was past tense. The current physician's orders, signed and dated on 11/19/15, contained an order for "Bactroban	F 309	Residents #1's attending physicians were notified that the facility failed to hold Bumex per physician ordered parameters for administration. A facility Incident and Accident form was completed for this incident. **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):** Facility policy and procedures have been reviewed. 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 medication orders & treatment orders. The DON and/or Regional nurse consultant will inservice all licensed staff on the procedure for obtaining, transcribing, and completing physician ordered medication and treatment orders .	

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F 309	Continued From page 3 2% ointment...apply to each nostril TID (three times a day) x five days." The order was given on 11/11/15 to treat MRSA colonized in the resident's nose. The TAR (treatment administration records) for November 2015 were reviewed for administration. The Bactroban was provided from 11/11/15 through 11/20/15. This administration encompassed ten days rather than the five days ordered by the physician. On 1/12/15 at 11:10 AM the DON (director of nursing) was asked about the order. She informed the surveyor that the order had been input to the computer without an end date and it was an oversight on the part of the staff member entering the order. No other information was provided prior to the survey team exit. * Bactroban is an antibiotic, is used to treat impetigo as well as other skin infections caused by bacteria. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a688004.html 2. Facility staff failed to administer Resident #20's Albuterol/Atrovent** nebulizer treatments per physician's order. The resident's clinical record was reviewed on 1/13/16 at 9:30 AM The resident was admitted on 1/7/16. His admission diagnoses included COPD (chronic obstructive pulmonary disorder.)	F 309	**Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will audit/review all MAR's weekly 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: 2-19-16**	

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The facility staff had not yet completed the admission MDS (minimum data set) assessment or CCP (comprehensive care plan) on this resident. His physician admission orders were in place as the admission care plan.

The physician's admission orders (implemented 1/7/16) signed and dated 1/12/16 contained: "Ipratropium (Atrovent)-Albuterol 18-103 micrograms inhaler give one inhalation QID (four times a day.)"

The aforementioned order was discontinued by the physician and a telephone order was provided on 1/8/16 at 8:00 PM : ".....Start Albuterol 0.083% give 1 UD (unit dose) via neb (nebulizer) Q (every) 6 hours....COPD...Start Ipratropium (Atrovent) BA 0.02% (one) via neb Q 6 hours....COPD...."

On 1/9/16 (no time provided) a second telephone order from the physician contained the following: "....(arrow down sign indicating "reduce") Albuterol/ unit dose QID....Atrovent with mask...."

The surveyor reviewed the MAR (medication administration record) for January 2016 from the admission date until 1/13/16. On 1/8/16 the Albuterol/Atrovent inhaler was administered at 9 AM, 1 PM, 5 PM and 9 PM per the physician's order.

The following was observed on the MAR:
1/9/16 - Albuterol/Atrovent administrations via nebulizer at 12 AM, 6 AM, 12 PM, 6 PM.
1/10/16 - Albuterol/Atrovent Neb (nebulizer) treatments at 12 AM, 6 AM, 9 AM, 12 PM, 1 PM, 5 PM, 6 PM, 9 PM.

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1/11/16 - Albuterol/Atrovent neb treatments at 12 AM, 6 AM, 9 AM, 12 PM.

On 1/13/16 at 10:00 AM the facility DON was asked why the resident was getting nebulizer treatments every three hours/ 8 times a day, rather than every six hours (QID) as ordered. The DON informed the surveyor the staff had gotten two telephone orders from the physician and had neglected to delete the first one from the computer after receiving the second order.

On 1/13/16 at 11:30 AM the ADON (facility assistant director of nursing) provided the surveyor with a new telephone order from the physician. The ADON stated, "I called the physician and had the order clarified for the nursing staff." The new order from the physician was for Albuterol/Atrovent nebulizer treatments to be provided four times a day (or every six hours.)

Documentation reviewed during the critical time frame yielded no negative outcome apparent to the resident due to the additional administrations.

No additional info was provided prior to the survey team exit.

** Albuterol/Atrovent: The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Albuterol and ipratropium combination is used by people whose symptoms

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have not been controlled by a single inhaled medication. Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a601063.html

3. Failed to follow orders for medication administration re: blood pressure parameters for Resident #1.
Resident #1 was readmitted to the facility on 1/9/16 however, the resident was originally admitted to the facility on 2/20/15. Resident #1 had the following diagnoses of, but not limited to: ascites* (abnormal buildup of fluid in the abdomen), osteomyelitis** (infection of the bone) of stage IV pressure ulcer***, diabetes, chronic Hepatitis C*^ (an inflammation of the liver. Hepatitis C, is caused by the hepatitis C virus (HCV)), encephalopathy**^ (Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure), neuromuscular dysfunction of bladder, heart failure and kidney failure.
Resident #1's MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 1/13/16 coded Resident #1 with a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicating the resident was cognitively intact. Resident #1 was also coded as needing extensive assistance by 2 staff members for bathing and dressing.

During review of the clinical record, on 1/12/16 for Resident #1, it was noted that the following order was on the MAR (Medication Administration

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Record) for January, 2016: "Bumex ***^1 mg (milligram) Tablet Take 1 Tab (tablet) PO (by mouth) BID (twice a day) Hold if SBP (Systolic Blood Pressure) < (less than)100 ". On 1/11/16 at 9 am, the nurse documented on the MAR that the resident had a BP of "92/60" and that the dose of Bumex was administered to Resident #1.
***^Bumex (Bumetanide) is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease. Other uses for this medicine: Bumetanide is also sometimes used to treat high blood pressure.
IMPORTANT WARNING: Bumetanide is a strong diuretic ('water pill') and may cause dehydration and electrolyte imbalance. It is important that you take it exactly as told by your doctor.

On 1/12/16 at 4:30 p.m. in the ADON (assistant director of nursing) office, the ADON was notified of and interviewed regarding the above documented findings on Resident #1's MAR for January, 2016. The ADON stated "They should have held that dose of medicine".
On 1/12/16 at 5 p.m. in the conference room, the administrator, director of nursing, ADON and corporate nurse were notified of the above documented findings.
No further information was provided to the surveyor prior to the exit conference on 1/13/16.

References:

* This information was obtained from the website: <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022961/>

** This information was obtained from the website:

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<https://www.nlm.nih.gov/medlineplus/ency/article/000437.htm>

*** A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.
Category/Stage IV: Full thickness tissue loss
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable. This information was obtained from the website:
<http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/>

*^ This information was obtained from the website:
<https://www.nlm.nih.gov/medlineplus/hepatitisc.html#summary>

**^ This information was obtained from the website:
<http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm>

***^ This information was obtained from the website:
<https://www.nlm.nih.gov/medlineplus/druginfo/m

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F 309	Continued From page 9 eds/a684051.html> F 425 SS=D 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and staff interview, it was determined that the facility staff failed to ensure IV (intravenous) antibiotic medication was obtained and available for administration for 1 of 26 residents in the survey sample, (Resident #1); and failed to dispose of expired medications for 1 of 26 Residents, Resident #18. 1. Facility staff failed to ensure Resident #1's	F 309 F 425	**F425** **Corrective Action(s):** Resident #11's attending physician was notified that the resident was not administered the Cefepime antibiotic per physician order. A Facility Incident & Accident Report has been completed for this incident. Resident #18's expired antibiotics were removed from the medication room refrigeration and destroyed. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all current resident medications in the medication carts for availability as well as all medication rooms to include medication refrigerators to identify any unavailable or expired medications. Any/all negative findings will be corrected at time of discovery. A Facility Incident & Accident Report will be completed for each incident identified. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The licensed nursing staff will be inserviced by the pharmacy consultant and/or DON on the policy for monitoring resident medications to include, proper labeling, dating and availability. As well as the removal of all expired medications to include all medications and biological from the medication rooms and medication carts.	

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F 425	Continued From page 10 physician ordered IV (intravenous) antibiotic medication was obtained an available for administration on 1/9/16 at 9:00 p.m., and 1/10/16 at 9:00 a.m. 2. The facility staff failed to dispose of Resident # 18's expired medication. The medication room on C wing included expired IV (intravenous) vancomycin (antibiotic). This medication was labeled as belonging to Resident #18 and had an expiration date of 12/02/15. The findings include: 1. 1. Facility staff failed to ensure Resident #1's physician ordered IV (intravenous) antibiotic medication was obtained an available for administration on 1/9/16 at 9:00 p.m., and 1/10/16 at 9:00 a.m. Resident #1 was readmitted to the facility on 1/9/16 however, the resident was originally admitted to the facility on 2/20/15. Resident #1 had the following diagnoses of, but not limited to: ascites* (abnormal buildup of fluid in the abdomen), osteomyelitis** (infection of the bone) of stage IV pressure ulcer***, diabetes, chronic Hepatitis C*^ (Hepatitis is an inflammation of the liver. One type, hepatitis C, is caused by the hepatitis C virus (HCV)), encephalopathy**^ (Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure), neuromuscular dysfunction of bladder, heart failure and kidney failure. Resident #1's MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 1/13/16 coded Resident #1 with a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicating the resident was cognitively intact. Resident #1 was also coded as needing extensive assistance by 2 staff	F 425	**Monitoring:** The DON is responsible for maintaining compliance. The DON, and/or designee will perform weekly medication Cart & Medication Room audits to monitor for compliance. Detail findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 2-19-16**	

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members for bathing and dressing.
During the review of Resident #1's clinical record on 1/12/16, it was documented on the MAR (Medication Administration Record) dated January, 2016 under details that the medication Cefepime (antibiotic***^) was "Unavailable ..." for staff to administer as ordered on 1/9/16 for the 9 p.m. dose. Resident #1 had been discharged from the hospital on 1/9/16 and arrived at the facility on this date at 8 p.m. The resident had arrived to the facility with the following physician order: "Cefepime 2 gram Solution Take 12 gram via (by) IV (intravenous) Q (every) 12 hrs. Dx (diagnosis): Wound Infection". Resident #1 had a discharge diagnosis of Osteomyelitis from the hospital. On 1/10/16 at 9 a.m., it was documented on the detail of the resident's MAR for the medication of Cefepime that this drug was "unavailable from pharmacy, pharmacy and md (medical doctor) notified". The surveyor did not find a physician order for this date on the clinical record.

At 4:35 p.m., the assistant director of nursing was asked to review Resident #1's MAR for 1/9/16 and 1/10/16. The assistant director of nursing stated, "The IV antibiotic was not given on 1/9 at 9 p.m. because it was unavailable from the pharmacy and it was to start in the am (morning). That is what the nurse has written in here. Then on 1/10 at 9 a.m., the nurse has written that the medicine was unavailable from pharmacy, pharmacy and MD notified. Then 1/10 at 9 p.m. no one has charted that the medicine was given". The surveyor asked the assistant director of nursing what the nursing staff was to do for a medicine that was not available from the pharmacy. The assistant director of nursing stated, "Call the pharmacy, then get the medicine

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from the back up pharmacy, so the medicine can be given".

On 1/12/16 at 5 p.m. in the conference room, the administrator, director of nursing, assistant director of nursing and the corporate nurse were informed of the above documented findings. The surveyor asked what the staff was to do in the event that a medication was not available at the time it was to be given. The corporate nurse stated, "In the event like this, what should happen, the staff is to call the pharmacy, notify the physician and write an order as to what the physician wants to do in this case".

On 1/13/16 at 7:55 a.m. the director of nursing gave the surveyor a copy of the policy titled, "7.0 Medication Shortages/Unavailable Medications". Under the "Applicability" section of the policy it documented, "This Policy 7.0 sets forth procedures relating to medication shortages and unavailable medications ...". Under the "Procedure" section of the policy the following was documented in part:

3. "...If a medication shortage is discovered after normal Pharmacy hours:

3.1 A licensed Facility nurse should obtain the ordered medication from the Emergency Medication Supply.

3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include:

3.2.1 Emergency delivery; or,

3.2.2 Use of an emergency (back-up) Third Party Pharmacy.

4. If an emergency delivery is unavailable,

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Facility nurse should contact the attending physician to obtain orders or directions ...

8. When a missed dose is unavoidable, Facility nurse should document the missed dose and the explanation for such missed dose on the MAR ...and in the nurse's notes per Facility policy. Such documentation should include the following information:

8.1 A description of the circumstances of the medication shortage;

8.2 A description of Pharmacy's response upon notification; and

8.3 Action(s) taken".

No further information was provided to the surveyor prior to the exit conference on 1/13/16.

References:
* This information was obtained from the website: <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022961/>

** This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/000437.htm>

*** A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.
Category/Stage IV: Full thickness tissue loss
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and

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these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable. This information was obtained from the website: <http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/>

*^ This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/hepatitisc.html#summary>

**^ This information was obtained from the website: <http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm>

***^ Cefepime injection is in a class of medications called cephalosporin antibiotics. It works by killing bacteria. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a698021.html

2. The facility staff failed to dispose of an expired medication. The medication room on C wing included expired IV (intravenous) vancomycin (antibiotic). This medication was labeled as belonging to Resident #18 and had an expiration date of 12/02/15.

Resident #18 was admitted to the facility on 01/14/15. Diagnoses included, but were not

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limited to, hypertension, anxiety, diabetes, chronic viral hepatitis, and depression.

Section C (cognitive patterns) of the Resident 18's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/21/15 coded the resident as scoring 15 out of a possible 15 points on the BIMS (brief interview for mental status), indicating the resident was cognitively intact.

The Residents clinical record included a POS (physician order summary) that included and documented the order "VANCOMYCIN PER PHARMACY." The date on this order was 11/13/15. The clinical record also included a physician ' s order dated 11/14/15 to "START VANCOMYCIN 1 GM (gram) IV (intravenous) EVERY 24 HOURS." The vancomycin had been discontinued on 12/08/15.

On 01/12/16 at approximately 10:55 a.m. the surveyor and LPN (licensed practical nurse) #1 entered the medication room on the C wing. The refrigerator included 3 bags of IV vancomycin. All 3 bags of the vancomycin were labeled with Resident #18's name and had an expiration date of 12/02/15.

LPN #1 stated that Resident #18 was no longer receiving the vancomycin and she would dispose of the medication.

The administrator, DON (director of nursing), and ADON (assistant director of nursing) were notified of the expired medication in a meeting with the survey team on 01/12/16 at approximately 5:05 p.m.

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F 425	Continued From page 16 On 01/13/16 at approximately 2:30 p.m. the DON provided the surveyor with a copy of the facility policy/procedure titled "Disposal/Destruction of Expired or Discontinued Medications" with an effective date of 12/01/07. This policy/procedure read in part "...Once an order to discontinue a medication is received, Facility staff should remove this medication from the resident's medication supply...Facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction..." No further information regarding the expired vancomycin was provided to the survey team prior to the exit conference.	F 425		
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. (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	F 441	**F441** **Corrective Action(s):** CNA #1 has been inserviced on proper use of PPE when rendering care to residents on isolation, hand washing and infection control practices during ADL care for resident #6. An Incident & Accident form was completed for each incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All residents on isolation may have the potential to be affected by improper use of PPE, hand washing and improper infection control techniques. The DON and/or Unit Manager will conduct audits on residents on isolation to observe proper infection control practices, proper PPE use and hand washing during resident care. 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.	

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F 441	Continued From page 17 (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 observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to follow established infection control guidelines for 1 of 26 Residents, Resident #6. The findings included. Resident #6 was on contact isolation for MRSA (methicillin-resistant staphylococcus aureus). CNA (certified nursing assistant) #1 was observed by the surveyor to be in Resident #6's room with no PPE (personal protective equipment) in place. CNA #1 was observed by the surveyor to touch items in the room with her bare hands.	F 441	**Systemic Change(s):** The facility policy and procedures have been reviewed and no changes are warranted at this time. All nursing staff will be inserviced on the facility policy and procedure on infection control to include the proper use of PPE for residents on isolation by the DON and/or Regional Nurse consultant. **Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will perform random weekly audits to monitor nursing staff for compliance. Any negative findings will addressed at time of discovery and disciplinary action taken as warranted. 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: 02-19-16**	

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According to the CDC (centers for disease control) MRSA is a bacteria that is resistant to many antibiotics.

Resident #6 was admitted to the facility 06/25/14 and was readmitted on 01/08/16. Diagnoses included, but were not limited to, MRSA wound and nares, gastroesophageal reflux disease, diabetes, hypertension, and stage IV pressure ulcer to right gluteus and sacrum.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/28/15 scored the Resident 15 out of a possible 15 points on the BIMS (brief interview for mental status). Indicating the Resident was alert and orientated. Section G (functional status) was coded to indicate the Resident required extensive assistance of two staff for bed mobility and dressing. Eating was coded to indicate the Resident was independent with set up help only. Section H (bladder and bowel) was coded to indicate the Resident had a colostomy and urostomy.

The Residents CCP (comprehensive care plan) included the problem area of MRSA of sacral wound receiving zyvox (antibiotic) and MRSA of nares receiving bactroban (topical antibiotic). Approaches included, but were not limited to, provide contact precautions, provide gloves, gown, mask, place sign on door, visitor to report to NS (nurses station) before entering.

The clinical record included a nursing entry documented on 01/08/16 by LPN #3 that read in part "Res. (resident) admitted back to facility, res clean and dry upon arrival @ approx.

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(approximately) 1645 (4:45 p.m.). Verified medications with Dr.____ (name omitted)...Res requires isolation precautions r/t (related to) MRSA of nares and Sacrum wound."

On 01/11/16 at approximately 4:15 p.m. the surveyor observed a plastic bin outside of the Resident #6's room. This bin included disposable gowns, gloves, and masks. Inside the room the surveyor was able to observe a red barrel. The surveyor was also able to observe a sign on the outside of the door frame that read "Attention please see nurse before entering room thank you."

On 01/12/16 at approximately 1:05 p.m. the surveyor observed CNA #1 in Resident #6's room. CNA #1 did not have on any protective equipment. The surveyor observed CNA #1 moving Resident #6's over the bed table and assisting the resident with her meal tray.

Upon exiting the room the surveyor asked CNA #1 about being in the room with no PPE in place. CNA #1 verbalized to the surveyor that when she entered the room she hadn't realized the resident had returned from her medical appointment.

On 01/12/16 at approximately 1:15 p.m. the surveyor applied PPE and entered the resident's room. Resident #6 was interviewed and asked about her appointment. Resident #6 was then asked if the staff wore PPE when entering her room. Resident #6 replied that they did.

On 01/12/16 at approximately 1:40 p.m. the surveyor notified the corporate nurse that CNA #1 was observed to be in Resident #6's room with no PPE in place.

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The corporate nurse provided the surveyor with a copy of "CDC Guideline for Isolation Precautions: Table 2." These guidelines read in part "...Skin or Wound Infection Abscess or draining wound that cannot be covered...Staphylococcus aureus (MSSA or MRSA)...Contact Precautions..."

On 01/12/16 at approximately 1:45 p.m. the surveyor interviewed LPN (licensed practical nurse) #2. The DON (director of nursing) had identified LPN #2 as the QA (quality assurance) nurse and infection control nurse. LPN #2 stated that Resident #6 had MRSA in her wound and nares. When asked if she would expect staff entering the room to wear PPE LPN #2 verbalized to the surveyor that she would. LPN #2 checked CNA #1's education record and stated that CNA #1 had been inserviced on infection control on 08/08/15.

On 01/12/16 the facility staff added the physicians order resident requires contact isolation precautions related to MRSA of nares and sacral wound to the current POS (physician order summary).

The administrator, DON (director of nursing), and ADON (assistant director of nursing) were notified of the infection control issue regarding Resident #6 in a meeting with the survey team on 01/12/16 at approximately 5:05 p.m.

No further information regarding the infection control issue was provided to the survey team prior to the exit conference.

F 502 SS=E	483.75(j)(1) ADMINISTRATION	F 502	**F502** **Corrective Action(s):**

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F 502	Continued From page 21 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 labs (laboratory tests) as ordered by the physician for 2 of 26 residents in the survey sample, Residents #7 and #8. 1. For Resident #7, the facility staff failed to obtain the physician ordered labs HgbA1c. 2. For Resident #8, the facility staff failed to obtain PT/INR labs as ordered by the physician. The findings included. 1. For Resident #7, the facility failed to obtain HgbA1c lab tests that had been ordered by the physician to be obtained every 3 months. No HgbA1c labs had been obtained after 02/06/15. The lab test HgbA1c (hemoglobin A1c*) is a blood test that provides information about an individual's average level of blood glucose, also called blood sugar, over the past 3 months. Resident #7 was admitted to the facility 04/06/13. Diagnoses included, but were not limited to, diabetes, chronic kidney disease, hypertension, Alzheimer's disease, and gastroesophageal reflux disease. Section C (cognitive patterns) of the Residents	F 502	Resident #7's attending physician has been notified that the facility failed to obtain a HgbA1c ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs. Resident #8's attending physician has been notified that the facility failed to obtain a PT/INR as ordered by the physician. As well as failed to obtain PT/INR timely 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. **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.	

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F 502	Continued From page 22 quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/16/15 was coded 1/1/2 indicating the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. Section I (active diagnoses) included diabetes. The clinical record included the following. 1. Current physician signed (12/13/15) POS (physician order summary) that included an order for the laboratory test "HGBA1C Q (every) 3 MONTHS DX. (Diagnosis) DM (diabetes mellitus)." 2. Original physician signed order dated 02/05/15 for "HgbA1C in am dx. DM. HgBA1C every 3 months..." 3. Results of an HgbA1C lab test obtained on 02/06/15. Results were documented as high at 6.4 the reference range referenced on the lab was 4.5-6.2. The physician had signed this lab on 02/06/15. 4. Order for blood sugars as needed for signs/symptoms of hypo (low) or hyper (high) glycemia. The surveyor was unable to locate any HgbA1c laboratory tests in the clinical record obtained after 02/06/15. Resident #7 was not receiving any medications to control his blood sugars. The surveyor did not locate any information in the clinical record to indicate the Resident had any hypo and/or hyperglycemic episodes. The surveyor reviewed the eMARs (electronic medication administration records) from March 1, 2015-January 13, 2016 and was unable to find any documentation on the eMARs to indicate the facility staff had obtained	F 502	**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: 2-19-16**	

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	495259	A. BUILDING _____ B. WING _____	01/13/2016

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the Residents blood sugar using the as needed order.

The DON (director of nursing) was asked about the missing lab results on 01/13/16 at approximately 7:40 a.m.

On 01/13/16 at approximately 10:50 a.m. the DON verbalized to the surveyor that Resident #7's HgbA1c labs had not been obtained after 02/06/15.

The administrator, DON (director of nursing), ADON (assistant director of nursing), and nurse consultant were notified of the missing labs during a meeting with the survey team on 01/13/16 at approximately 1:55 p.m.

No further information regarding the missing HgbA1c labs was provided to the survey team prior to the exit conference.

* This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/003640.htm

2. For Resident #8, the facility staff failed to obtain PT/INR (prothrombin time/international normalized ratio) labs as ordered by the physician. The facility failed to obtain a PT/INR lab test ordered on 12/04/15 and failed to obtain PT/INR labs ordered on 01/01/16 and 01/11/16 in a timely manner.

According to the National Institute of Health a prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot. The most common reason to perform this test is to monitor your

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levels when you are taking a blood-thinning medicine called warfarin (coumadin).
Resident #8 was admitted to the facility 07/27/15. Diagnoses included, but were not limited to, atrial fibrillation, chronic obstructive pulmonary disease, hypertension, gastroesophageal reflux disease, and BPH (benign prostatic hyperplasia).
Section C (cognitive patterns) of the residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/24/15 had scored the resident 15 out of a possible 15 points for the BIMs (brief interview for mental status). Indicating the Resident was alert and orientated.
The clinical record included the following.

A Physician order dated 11/30/15 and signed by the physician on 12/08/15 to "Repeat PT/INR on 12/4/15 DX (diagnosis)-A-Fib (atrial fibrillation)." The surveyor was unable to locate the results of this lab test.
Physician order dated 11/24/15 to "Repeat PT/INR on 12/7/15." The results of this lab were documented on the lab sheet as PT 33.9 (high) and INR 3.05 (high). The reference range on the lab for the PT was documented as 9.6-11.6 and the INR reference range was documented as 0.91-1.09. The physician was notified and no changes were made to the current dosage of coumadin (5 mg at bedtime).
On 12/09/15 the physician changed the Residents coumadin to 4 mg at bedtime and ordered the Residents PT/INR to be obtained in 2 weeks. This lab was obtained on 12/23/15 the results were documented as PT 46.6 and INR 4.15. The physician was notified and new orders were obtained to hold coumadin X 2 days and restart coumadin 5 mg on 12/25/15 at bedtime. A review of the Residents eMAR's (electronic medication

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administration records) indicated the medication had been held and restarted per the physician's orders.
An order dated 12/31/15 to "Collect PT/INR in A.M." There were no results in the clinical record for 01/01/16 ordered lab test. The clinical record did include a PT/INR obtained on 01/03/16. Results were documented as PT 65.3 and INR 5.73. Documentation on this lab indicated the lab had contacted the facility and reported the lab results. The physician was notified on 01/03/16 and new orders were given from the physician to "Hold Coumadin 5 mg PO (by mouth) Q (every) HS (bedtime/hour of sleep) until further orders received. Collect CMP (comprehensive metabolic panel), CBC (complete blood count), PT/INR in A.M." These labs were obtained as ordered on 01/04/16 and reported to the physician. The results of the PT were documented as 58.9 and the INR results were documented as 5.19. The Residents RBC (red blood count) was documented as low at 3.80, hemoglobin was documented as low at 11.5, and hematocrit was documented as low at 35.5. The previous RBC obtained on 09/08/15 was documented as 3.09, hemoglobin 9.4, and hematocrit as 30.2. Indicating the RBC, hemoglobin, and hematocrit labs had improved since 09/15.
The physician was notified on 01/04/16 of the lab results and new orders were obtained on 01/04/16 to continue to hold coumadin and repeat PT/INR on 01/06/16. This lab was obtained as ordered PT (27.9) and INR (2.53). The physician was notified of the results on 01/06/16 and new orders were obtained to "Start coumadin 3 mg po QHS...Repeat PT/INR on 1/11/16."
There were no results in the clinical record for the PT/INR ordered to be obtained on 01/11/16. The DON (director of nursing) did provide the

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F 502	Continued From page 26 surveyor with a copy of a PT/INR obtained on 01/12/16. The results were documented as PT (20.4) and INR (1.87). The physician was notified and new orders were obtained on 01/12/16 to increase coumadin to 4 mg at bedtime on Tuesdays and 3 mg of coumadin on all other days. Repeat PT/INR on 01/26/16. On 01/12/16 the DON was asked the procedure for obtaining labs. The DON verbalized to the surveyor that the orders for the labs were placed in a lab book and the hospital would obtain the labs. The DON stated that if the hospital did not obtain the labs the facility was responsible for obtaining the labs. The DON added she did not know why the labs were not obtained as ordered. During a meeting with the survey team on 01/13/16 at approximately 1:55 p.m. the administrator, DON, ADON (assistant director of nursing), and nurse consultant were notified of the missing PT/INR lab test on 12/04/15, the PT/INR ordered on 01/01/16 was not obtained until 01/03/16, and the PT/INR ordered to be obtained on 01/11/16 was not obtained until 01/12/16. The Resident was observed numerous times by the surveyor during the course of survey process and no problems were identified. No further information regarding Resident #8's PT/INR lab tests was provided to the survey team prior to the exit conference.	F 502		
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	F 514	**F514** **Corrective Action(s):**	

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F 514	Continued From page 27 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient 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, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for 3 of 26 residents in the survey sample, (Residents #1, 11 and 13). 1. Resident #1's clinical record contained inaccurate physician progress notes. 2. Resident #11's clinical record contained an inaccurate laboratory test draw and an undated physician order. 3. Resident #13's clinical record contained an inaccurate Plan of Care. The findings included: 1. Resident #1 was readmitted to the facility on 1/9/16 however, the resident was originally admitted to the facility on 2/20/15. Resident #1 had the following diagnoses of, but not limited to ascites, heart failure and kidney failure. Resident #1's MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 1/13/16 coded Resident #1 with a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicating the resident was cognitively intact. Resident #1 was also coded	F 514	Resident #1's attending physician has been notified of the inaccuracy with the resident's gender in the progress notes and the progress notes have been corrected. A facility incident and accident form has been completed for this incident. Resident #11's attending physician has been notified that the facility staff failed to correctly date a physician telephone order to draw a physician ordered CMP lab on the directed day, Friday. The lab was obtained on Monday, 3 days late. A facility incident and accident form has been completed for this incident. Resident #13's code status has been reviewed by the attending physician and she is a DNR. The physician orders and physician progress note reflects the correct code status. A facility Incident and Accident form was completed for each incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of resident medical records for the last 30 days will be conducted by the DON and ADON to identify residents at risk for inaccurate documentation and inaccurate Code Status. All negative findings will be clarified and/or corrected as applicable 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 28	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 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 medical record, the Physician Orders, the MAR's, TAR's, ADL records and accurate CODE status according to the acceptable professional standards and practices.	

as needing extensive assistance by 2 staff members for bathing and dressing.
During Resident #1's clinical record review on 1/12/16, the physician's progress notes documented under Examination, "Alert, oriented X (times) three white female not in any acute distress ..." These progress notes were documented with Resident #1's name on them. The progress notes that were documented with the above statement were dated for 8/11/15, 8/26/15, 8/29/15, 9/23/15, 10/1/15, 10/8/15 and 11/24/15. Resident #1 was coded, on the MDS with ARD dates of 11/25/15 and 1/13/16, in Section A0800 as being a "Male".

In the conference room on 1/12/16 at 11:30 am, the surveyor informed the corporate nurse of the above documented findings. The corporate nurse stated "We have got to get that fixed".

The administrator, director of nursing, assistant director of nursing and the corporate nurse were notified, of the above findings as documented above, on 1/12/16 at 5 pm in the conference room.

No further information was provided to the surveyor prior to the exit conference on 1/13/16.

2. Resident # 11 was admitted to the facility on 11/23/15 with the following diagnoses of, but not limited to status post fracture hip, weakness, anxiety, high cholesterol, high blood pressure, heart disease, depressive disorder and dementia. During Resident #11's clinical record review on 1/12/16, it was noted a physician order was not dated when the nurse wrote the order. This order was in between the orders that were dated for 12/22/15 and 12/28/15. The order documented,

Monitoring:
The DON is responsible for maintaining compliance. The DON, ADON and/or designee will audit medical records, MAR's, TAR's, ADL records 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: 2-19-16

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"CMP (Comprehensive Metabolic Panel) Friday ... ".

On 1/12/16 at 4pm in the B wing nurses' station, the surveyor showed RN (registered nurse) #5 the undated order in the clinical record of Resident #11. RN #5 stated, "I forgot to date the order".

Upon further review of the clinical record of Resident #5, it was noted in the laboratory test results section a CMP (complete metabolic panel) was drawn by the lab staff on 12/28/15, which was on a Monday. There was no lab result on a Friday for a CMP in the clinical record for the dates of 12/22/15 until 12/28/15, which was the date the CMP was drawn on.

The administrator, director of nursing, assistant director of nursing, and corporate nurse was notified of the above documented findings on 1/12/16 at 5pm in the conference room.

On 1/13/16 at 2:20 pm, the director of nursing gave the surveyor a copy of the policy titled, "Telephone Orders". The policy documented, "Verbal telephone orders may be accepted from each resident's Attending Physician". Under: "Policy Interpretation and Implementation" of this policy the following was documented:
1. " Verbal telephone orders may only be received by licensed personnel ...
2. The entry must contain the instructions from the physician, date, time and the signature and title of the person transcribing the information ... "

No further information was provided to the surveyor prior to the exit conference on 1/13/16.

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3. Resident #13 was admitted to the facility on 6/8/15 with the following diagnoses of, but not limited to dementia, osteoporosis, anxiety, major depressive disorder and high blood pressure. Resident #13 was coded on the MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 11/30/15 as having short term and long term memory problems. Resident #13 was also coded as needing extensive assistance with 2 staff members for bathing and dressing.

During review of Resident #13's clinical record on 1/12/16, a DNR (Durable Do Not Resuscitate Order) was dated for 6/8/15 and was signed by the FNP (Family Nurse Practitioner) and the POA (Power of Attorney). Upon further review of the clinical record it was noted that the POC's (Plan of Care) dated for the months of 6/15, 7/15, 8/15, 9/15, 10/15 11/15 and 12/15 documented, "Full Code" for this resident.

RN (registered nurse) #6 was interviewed by the surveyor on 1/12/16 at 1:30 pm in the nurses' station on the C wing of the facility. RN #6 stated, "I don't know when the DNR was signed. I thought that we had this and the MD (medical doctor) hadn't signed it until now, but I can't find anything written down in the progress". At 1:35 p.m., in the same nurses' station, the director of nursing (DON) was informed of the above documented findings. The director of nursing stated, "When they received the DNR it (plan of care) should had been changed from full code".

On 1/12/16 at 5 pm in the conference room, the administrator, director of nursing, assistant director of nursing and corporate nurse was notified of the above documented findings.

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No further information was provided to the surveyor prior to the exit conference on 1/13/16.

VDH

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F 000	Initial Comments	F 000		

An unannounced biennial State Licensure Inspection was conducted 01/11/16 through 01/13/16. Corrections are required for compliance with Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 120 certified bed facility was 112 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through #20) and 6 closed record reviews (Residents #21 through #26).

F 001 Non Compliance — F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.

12 VAC 5-371-140. Resident Behavior & Facility Practices.
12 VAC 5-371-140 (A,D.12,E.2,E.3): Cross reference to F-226.

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (A THRU G) Cross reference to F-309.

12 VAC 5-371-300. Pharmacy Services.
12 VAC 5-371-300 (A,C,G) Cross reference to F-425.

12 VAC 5-371-180. Infection Control.
12 VAC 5-371-180 (A,B,C) Cross reference to F-441.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

VDH

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12 VAC 5-371-310. Administration.
12 VAC 5-371-310 (A) Cross reference to F-502.

12 VAC 5-371-360. Clinical Records
12 VAC 5-371-360 (A,E,f,j) Cross Reference to F-514