HERITAGE HALL - LAUREL MEADOWS

Our Home, Our Family, Our Life, Too.

March 14, 2016

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

Mr. Miller,

Attached to this cover letter you will find Heritage Hall – Laurel Meadows 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) 398-2117.

Sincerely,

Wrightly Darnell

Wrightly Darnell
Administrator

16600 Danville Pike / Laurel Fork, Virginia 24352 / 276 398-2117 / Fax 276 398-3122
HEALTHCARE AND REHABILITATION CENTER
Managed by AMERICAN HEALTHCARE, LLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495323	A. BUILDING _____ B. WING _____	02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - LAUREL MEADOWS	16600 DANVILLE PIKE LAUREL FORK, VA 24352

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 02/22/16 through 02/24/16. 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 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #1 through #12) and 3 closed record reviews (Residents #13 through #15).

F 155 SS=D — 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES — F 155

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

F155
Corrective Action(s):
Resident's #10 & #11 have had their DDNR form and physician orders reviewed by the attending physician and they have been updated and correctly completed to reflect resident #10 & #11's code status. An Incident and Accident form was completed for this incident.

Identification of Deficient Practice(s) & Corrective Action(s):
All other residents may have been potentially affected. The Admission Director will review all resident's medical records and contact all responsible parties to verify each resident code status and advance directives to insure that the proper status has been explained and that written notification has been placed in the medical record.

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

Wrightly C. Darnell | Administrator | 3-14-16

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.

RECEIVED

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F 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure an accurate DNR (do not resuscitate) status for 2 of 15 Residents, Resident #10 and #11. The findings included: 1. For Resident #10, the facility staff failed to correctly code the DNR status on the physician's order summary. Resident #10 was admitted to the facility on 02/19/16. Diagnoses included but not limited to hypothyroidism, gastroesophageal reflux disease and pathological fracture. There is no MDS (minimum data set) completed at this time. Resident #10's clinical record was reviewed on 02/24/16. It contained a completed Virginia Department of Health DDNR (durable do not resuscitate) form signed and dated 02/22/16. The Resident's clinical record also contained a POS (physician's order summary) dated 02/19/16, which read in part "full code". The surveyor spoke with the DON (director of nursing) and nurse consultant on 02/24/16 at approximately 10:00 regarding the inconsistency of the DNR status. The DON and nurse consultant could not locate information that showed the Resident's change in code status. The concern of the inconsistent DNR status was brought to the attention of the administrative staff during a meeting on 02/24/16 at approximately 1130.	F 155	**Systemic Change(s);** The Facility policy and procedure was reviewed and no changes are warranted at this time. The Admissions Director has been in-serviced on the proper completion of a DDNR and Advance Directives when required. The Admission Director will discuss with each future Admission their advance directors and resuscitation status upon admission to the facility. Any/all concerns expressed will be reported to the Administrator. The Administrator & Director of Nursing will speak to those concerned or with questions about each area & follow through on all concerns to ensure proper resuscitation status is reflected in the medical record. **Monitoring:** The Admission Director is responsible for maintaining compliance. The Admission Director will audit all Residents medical records monthly to monitor compliance for having a current resuscitation order and/or advance directive Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. **Completion Date: April 8, 2016**	

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F 155	Continued From page 2 No further information was provided prior to exit 2. For Resident #11, the clinical record included a DDNR (durable do not resuscitate order). However, the clinical record also included a physicians order that read "FULL CODE." Resident #11 was admitted to the facility 01/25/16. Diagnoses included, but were not limited to, chronic kidney disease, dementia, hypertension, benign prostatic hyperplasia, dysphagia, and congestive heart failure. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/01/16 was scored 1 out of a possible 15 points. The Residents clinical record included a physician signed DDNR dated 01/17/16. The clinical record also included a POS (physician order summary) signed by the physician on 01/28/16 that read "FULL CODE." The administrator, DON (director of nursing), ADON (assistant director of nursing), and nurse consultant were notified of the above in a meeting with the survey team on 02/24/16 at approximately 11:25 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 155		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

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F 278	Continued From page 3 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based upon staff interview and clinical record review, the facility staff failed to have an accurate MDS assessment for 1 of 15 Residents in the survey sample (Resident #12). The findings included: The staff failed to have correctly code a flu vaccine on the MDS on Resident #12 when admitted to the facility.	F 278	**F278** **Corrective Action(s):** Resident #12's Admission MDS with an ARD of 2/17/16 was reviewed by the RCC and a modification was completed to accurately code section O for Flu Vaccine on the MDS. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all current resident assessments will be completed by the RCC and/or designee to ensure that MDS section O – Flu Vaccine is assessed and coded correctly. All negative findings will be reported to the RCC for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS. **Systemic Change(s):** The Resident Interdisciplinary Care Team have been in-serviced by the Regional Nurse consultant on the proper assessment and coding of all areas of the MDS to include section O of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data.	

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F 278	Continued From page 4 Resident #12 was admitted to the facility on 2/10/16 with the following diagnoses of, but not limited to acute respiratory failure, high blood pressure, diabetes, edema and gout. The admission MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/17/16 scored the resident as having a BIMS score of 12 out of a possible score of 15. The resident requires extensive assistance by staff for dressing and personal hygiene and total dependence on staff for bathing. During the clinical record review on 2/24/16, it was noted on the MDS that the resident was coded under Section " O " as not having received the flu vaccine in this facility. In the same section of the MDS, the resident was coded as a " 1 " which represents the resident not in this facility during this year ' s influenza vaccination season. On 2/24/16 at approximately 11:20 am in the director of nursing ' s office, the corporate nurse was notified of the above findings. The corporate nurse stated, " That ' s wrong. The MDS person coded this as a 1 instead of a 2." No further information was provided to the surveyor prior to the exit conference on 2/24/16.	F 278	**Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 8, 2016**	
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.	F 309		

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This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to follow physician orders for 3 of 15 Residents, Resident #4, #5, and #11.

The findings included.

1. For Resident #4, the facility staff failed to administer mucinex as ordered by the physician and failed to follow the bowel protocol.

Resident #4 was admitted to the facility 04/07/15. Diagnoses included, but were not limited to, cerebrovascular disease, diabetes, depressive disorder, anxiety disorder, chronic obstructive pulmonary disease, and shortness of breath.

Section C (cognitive patterns) of the Residents admission (readmission) MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/21/16 scored the Resident 9 out of a possible 15 points. Section G (functional status) was coded 3/3 for extensive assistance of 2 people for toilet use. Section H (bowel continence) was coded to indicate the Resident was always continent of bowel.

The Residents clinical record included a physicians order dated 02/11/16 for mucinex 600 mg (milligrams) PO (by mouth) q (every) 12 hours X 7 days.

A review of the Residents eMAR (electronic medication administration) for the month of February 2016 indicated the Resident only received the mucinex one time a day.

F309
Corrective Action(s):
Resident #4's attending physician was notified that the facility failed to administer Mucinex as ordered or follow the bowel protocol as ordered by the attending physician. A facility Incident and Accident form was completed for this incident.

Resident #5's attending physician was notified that the facility staff failed to follow the bowel protocol as ordered by the physician. A facility Incident and Accident form was completed for this incident.

Residents #11's attending physicians were notified that the facility failed to use the physician ordered wedge when up in wheel chair. 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, and Unit Manager 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.

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On 02/23/16 at approximately 9:40 a.m. the DON (director of nursing) and nurse consultant were notified of that the mucinex was given one time a day and not every 12 hours as ordered by the physician.

On 02/23/16 at approximately 10:15 a.m. the DON verbalized to the surveyor that the mucinex was put into the system incorrectly.

A review of the Residents BM's (bowel movements) for February 2016 indicated the Resident had a BM on 02/11/16 and did not have another BM until 02/16/16.

Resident #4 received colace 100 mg 2 tablets 200 mg everyday for constipation and had a physicians order for miralax powder mix 17 grams in water or juice PO BID (twice a day) PRN (as needed) constipation.

The facility used standing orders for constipation "MOM (milk of magnesia) 30 cc PO daily X 3 days. If no BM on 4th day give Dulcolax suppository one per rectum; if no results after 1 hr., give Fleets enema per rectum. If constipation recurs q3 days routinely, you may begin Senokot-S 1 tab PO twice daily and use above interventions p.r.n." (sic)

There was no documentation on the eMAR to indicate the bowel protocol had been followed or that the prn miralax had been administered from 02/11/16-02/16/16.

On 02/23/16 at approximately 11:40 a.m. the DON was notified that per the clinical record Resident #4 had not had a BM from 02/11/16 until

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 in-service all licensed staff on the procedure for obtaining, transcribing, and completing physician ordered medication and treatment orders.

Monitoring:
The DON will be responsible for maintaining compliance. The DON,

and/or Unit Manager 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: April 8, 2016

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02/16/16.

On 02/23/16 at approximately 4:40 p.m. during a meeting with the administrator, DON, ADON (assistant director of nursing), and nurse consultant the administrative staff were notified that the Residents mucinex was not given as ordered and the bowel protocol was not followed.

No further information regarding Resident #4 was provided to the survey team prior to the exit conference.

2. For Resident #5, the facility staff failed to follow the bowel protocol.

Resident #5 was admitted to the facility 12/22/13. Diagnoses included but were not limited to, dementia, hypertension, tachycardia, and dementia.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/09/15 scored the Resident 5 out of a possible 15 points. Section G (functional status) was coded 3/2 for toilet to use to indicate the Resident required extensive assistance of one person. Section H (bowel and bladder) was coded to indicate the Resident was always continent of bowel.

Resident #5's CCP (comprehensive care plan) included the problem/need area at risk for impaired bowel motility related to impaired physical mobility. Goals included will have a BM at least q (every) 3 days over the next quarter. Approaches included monitor BM documentation daily, document BM's daily, encourage fluids, and encourage good po (by mouth) intake.

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

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A review of the Residents bowel report for January 2016 indicated Resident #5 had a BM on 01/24/16 and did not have another BM until 01/30/16.

The facility used standing orders for constipation "MOM (milk of magnesia) 30 cc PO daily X 3 days. If no BM on 4th day give Dulcolax suppository one per rectum; if no results after 1 hr., give Fleets enema per rectum. If constipation recurs q3 days routinely, you may begin Senokot-S 1 tab PO twice daily and use above interventions p.r.n." (sic)

There was no documentation on the eMAR to indicate the bowel protocol had been followed.

The DON (director of nursing) was notified of the above on 02/23/16 at approximately 11:40 a.m.

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

3. For Resident #11, the facility staff failed to apply the Residents wedge as ordered by the physician.

Resident #11 was admitted to the facility 01/25/16. Diagnoses included, but were not limited to, chronic kidney disease, dementia, hypertension, benign prostatic hyperplasia, dysphagia, and congestive heart failure.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/01/16 was scored 1 out of a possible 15

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F 309	Continued From page 9 points. Section G (functional status) was coded to indicate the Resident used a wheelchair for mobility. The Residents CCP (comprehensive care plan) included the problem/need area of falls. Approaches included, but were not limited to, incline wedge to be placed in w/c (wheelchair) to keep hips back in chair and prevent sliding forward. The clinical record included a signed physicians (02/0416) order dated 01/28/16 for "Incline Wedge to be placed in W/C to keep hips back in chair and prevent sliding forward." On 02/24/16 at approximately 9:00 a.m. the surveyor and the DON (director of nursing) checked the Resident to see if the wedge was in place. The Resident was observed to be up in his wheelchair the wedge was not in place. During a meeting with the administrator, DON, ADON (assistant director of nursing), and nurse consultant on 02/24/16 at approximately 11:25 a.m. the administrative staff were notified that Resident #11 did not have their physician ordered wedge in place when checked by the surveyor and DON. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 309		
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	F 425		

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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 upon staff interview, facility document review and clinical record review, the staff failed to ensure medication was available for administration for 1 of 15 residents in the survey sample (Resident #2).
The findings included:
The staff failed to obtain Robitussin CF as ordered by the physician on 1/14/16 from the pharmacy.
Resident #2 was readmitted to the facility on 9/9/15 with the following diagnoses of, but not limited to chronic shortness of breath, chest pain, congestive heart failure, depression, Parkinson ' s Disease and Rheumatoid Arthritis.
Resident #2 MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 12/9/15 coded the resident

F425
Corrective Action(s):
Resident #2's attending physician has been notified that the facility failed to ensure that physician ordered medication Robitussin CF was available from pharmacy for administration to Resident #2. A facility Incident and Accident form has been completed for this incident.

Identification of Deficient Practices & Corrective Action(s):
All residents may have potentially been affected. A 100% review of all resident's medication regimes has been conducted by the DON, and/ or Unit manager to identify residents at risk. Residents found to be at risk due the medication being unavailable from the pharmacy will be corrected at time of discovery and their attending physicians will be notified. A facility Incident and Accident form has been completed for each.

Systemic Changes:
The Pharmacy Policy and Procedure has been reviewed and no changes are warranted. All licensed nursing staff have been in-serviced on the Policy and Procedure for medication administration to included medications that are unavailable or do not arrive at the facility timely from the pharmacy. The in-service will include the steps the nurse should take should a medication not be delivered timely from the pharmacy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495323	A. BUILDING _____ B. WING _____	02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - LAUREL MEADOWS	16600 DANVILLE PIKE LAUREL FORK, VA 24352

(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 425	Continued From page 11 was having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #2 was also coded as requiring extensive assistance with 2 staff members for personal hygiene and requiring total dependence on staff for bathing. During the clinical record review on 2/23/16, it was noted that the following physician ' s order was documented in the clinical record which stated, 1/14/16 ...Robitussin CF 10 ml (milliliters) po (by mouth) TID (three times a day) & q (every) 4 hours prn (as needed) cough for 7 days " . In the nursing note dated and timed for 1/14/16 at 10:44 pm, the nurse documented the following: " Clarification order may start Robitussin CF when arrives from pharm (pharmacy) MD (medical doctor) and RP (responsible party) aware " . On the MAR (Medication Administration Record) dated for January, 2016, this medication was not started until 1/16/16 at 6 am. On 2/23/16 at approximately 4 pm, the director of nursing, corporate nurse and administrator of the above documented findings. The director of nursing stated, " The staff is to call the pharmacy if it is after hours to obtain the medication. If for some reason the pharmacy cannot deliver the medication in a timely fashion, we do have a back up pharmacy that we can use to get medicine from " . The surveyor asked for the policy on obtaining medications from the pharmacy. At approximately 4:45 pm, the director of nursing brought to the surveyor the policy titled " LTC Facilities Receiving Pharmacy Products and Services from Pharmacy " . Under the Procedure section of the policy, it stated the following: " ...2. If a necessary medication is not contained within the Facility ' s interim/stat/emergency supply, and the Facility determines that an interim/stat/emergency	F 425	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Unit Manager will conduct medication reviews of resident medication orders each week coinciding with the Care plan calendar to check for the availability of all ordered drugs. All negative findings will be corrected at the time of discovery. Results of the reviews will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 8, 2016**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495323	A. BUILDING _____ B. WING _____	02/24/2016

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F 425	Continued From page 12 delivery is necessary, Facility should arrange either: 2.1 With the Pharmacy to include the interim/stat/emergency medication(s) in an earlier scheduled delivery or a special delivery, as required, or 2.2 For delivery by contract courier, or, 2.3 For the medication to be dispensed and delivered by a Third Party Pharmacy to ensure timely receipt ... " No further information was provided to the surveyor prior to the exit conference on 2/24/16.	F 425		
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 physician ordered lab tests for 1 of 15 Residents, Resident #3. The findings included. The facility staff failed to obtain the physician ordered lab tests BMP (basic metabolic panel), CBC (complete blood count), and magnesium. Resident #3 was admitted to the facility 07/07/15. Diagnoses included, but were not limited to, heart failure, hypertension, chronic kidney disease, diabetes, and cluster headaches.	F 502	**F502** **Corrective Action(s):** Resident #3's attending physician has been notified that the facility failed to obtain a BMP, CBC and a Magnesium level 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.	

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F 502 Continued From page 13

Section C (cognitive patterns) of the Residents admission (readmit) assessment with an ARD (assessment reference date) of 01/05/16 was coded with an 11 out of a possible 15 points.

The clinical record included a physicians order signed and dated 12/31/16 for the lab tests CBC, BMP and magnesium in 1 week.

The surveyor was unable to locate any results for these lab tests.

The DON (director of nursing) was notified of the missing lab results on 02/23/16 at approximately 2:40 p.m.

On 02/23/16 at approximately 4:40 p.m. during a meeting with the administrator, DON, ADON (assistant director of nursing), and nurse consultant the administrative staff were notified of the missing lab tests.

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

F 508 SS=D 483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS

The facility must provide or obtain radiology and other diagnostic 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 upon staff interview and clinical record review, the facility staff failed to obtain a chest

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 Regional Nurse Consultant will in-service all licensed staff on physician ordered laboratory-testing, protocols, & tracking system used.

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or Unit Manager 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: April 8, 2016

F 508

F508
Corrective Action(s):
Resident #2's attending physician has been notified that resident #2 did not get a 2 view chest x-ray done as ordered by the physician. Only a 1 view AP chest x-ray was completed. A Facility Incident/Accident form has been completed for this incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 508	Continued From page 14	F 508		

x-ray as ordered by the physician for 1 of 15 residents in the survey sample. (Resident #2)
The findings included:
The facility staff failed to obtain a 2 view chest x-ray on Resident #2 as ordered by the physician. Resident #2 was readmitted to the facility on 9/9/15 with the following diagnoses of, but not limited to chronic shortness of breath, chest pain, congestive heart failure, depression, Parkinson ' s Disease and Rheumatoid Arthritis. Resident #2 MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 12/9/15 coded the resident was having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #2 was also coded as requiring extensive assistance with 2 staff members for personal hygiene and requiring total dependence on staff for bathing.
During the clinical record review on 2/23/16, the following physician ordered was noted for 12/10/15: " 1. Chest x-ray 2 view ... " . The results of this chest x-ray ordered for 12/10/15 was also noted in the clinical record. In the Radiology Report dated for 12/10/15 under examination it was documented " CHEST - 1 View AP " .
On 2/23/16 at approximately 3:30 pm, the director of nursing was notified of the above documented findings. The director of nursing stated, " It was only done as 1 view instead of a 2 view chest x-ray " .
No further information was provided to the surveyor prior to the exit conference on 2/24/16.

Identification of Deficient Practice(s) & Corrective Action(s):
All other residents with physician ordered x-rays and lab work may have potentially been affected. A 100% audit of resident clinical records for physician ordered laboratory work and x-rays will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. A Risk Management Incident & Accident form will be completed and proper notification made to the resident's attending physician.

Systemic Changes:
The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced on the policy and procedure for obtaining resident laboratory tests and x-rays as ordered with the appropriate pre-procedure preparation orders.

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or Unit Manager will review all physician orders daily and as needed to ensure that physician ordered X-rays and lab work are being obtained and completed for residents as ordered by their attending physician. 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: April 8, 2016