STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495261	A. BUILDING _____ B. WING _____	C 03/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NRSG AND REHAB	122 MORVEN PARK ROAD NW LEESBURG, VA 20176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/15/17 through 3/17/17. 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 164 certified bed facility was 144 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #1 through #21) and five closed record reviews (Residents #22 through #26).	F 000		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide individualized activities according to the comprehensive assessment for one of 26 residents in the survey sample, Resident #1. The facility failed to provide activities according to	F 248	**F248** **Corrective Action(s):** Resident #1 has been reassessed for activities. Resident #1's plan of care was updated to reflect her activity needs and interests with appropriate interventions to meet her needs. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents with dementia and/or severe cognitive impairment may have been potentially affected. The facility conducted a 100% review of all residents with dementia and/or severely cognitive impairment to identify residents at risk. Residents identified at risk will have their care plans reviewed to determine if the resident's care plan has activities listed to meet the resident's individual psychosocial needs and interests. Any changes or additional findings will be added to their resident specific care plan. **Systemic Change(s):** The current facility policy and procedure has been reviewed and no changes are warranted at this time. The current Activities Director and Activity Assistants will review the Long Term Care regulation manual for providing activities and to develop activity programs to meet resident specific needs and interests.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Vorpahl	administrator	3/28/17

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the resident's assessed preferences on 3/15/17 and 3/16/17 for Resident #1.

The findings include:

Resident #1 was admitted to the facility on 4/15/16 with diagnoses including, but not limited to: Alzheimer's disease, chronic obstructive pulmonary disease (1), bipolar disorder, anxiety and depression. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 12/20/16, Resident #1 was coded as having both short term and long term memory difficulties, and as being moderately impaired for making daily decisions. She was coded as requiring the extensive assistance of two staff members for bed mobility, and as being dependent on staff for transfers and for locomotion around the unit. She was coded as being highly visually impaired.

The following observations were made of Resident #1 during the survey:
- 3/15/17 at 11:30 a.m. - The resident was reclined in her chair in the day room, yelling intermittently. No formal activity was taking place at this time.
- 3/15/17 at 2:00 p.m. - The resident was reclined in her chair in her room. The chair faced the television, which was in the far corner of the room. The resident's back was to the hallway. The television did not have sound coming from it.
- 3/15/17 at 5:10 p.m. - The resident was lying on her back in bed, with her eyes open. Her arms were reaching/grasping in the air. There was no television on or music playing in the room.
- 3/16/17 at 7:45 a.m. - The resident was reclined in her chair, and a CNA (certified nursing assistant) was pushing the chair into the day

Monitoring:
The Activities Director is responsible for maintaining compliance. Weekly audits of activity coding on Comprehensive MDS assessments and activity care plans will be conducted by the Activity Director and/or RCC coinciding with the MDS calendar to monitor for compliance. All negative findings will be reported to the Risk Management Committee for review. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice.
Completion date: 4/28/2017

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room. Resident #1 was yelling intermittently.
- 3/16/17 at 9:10 a.m. - The resident was reclined in her chair in her room, and her eyes were closed. The chair faced the television, which was in the far corner of the room. The resident's back was to the hallway. The television did not have sound coming from it.
- 3/16/17 at 10:15 a.m. - The resident was reclined in her chair in her room, and her eyes were closed. The chair faced the television, which was in the far corner of the room. The resident's back was to the hallway. The television did not have sound coming from it. In the unit's dayroom, a word game activity was occurring. In the unit's dining room, a movie musical was being shown on the television
- 3/16/17 at 10:45 a.m. - The resident was reclined in her chair in her room, and her eyes were open. The chair faced the television, which was in the far corner of the room. The resident's back was to the hallway. The television did not have sound coming from it. In the unit's dayroom, the television was tuned to a soothing music station. In the unit's dining room, a movie musical was being shown on the television.
- 3/16/17 at 11:35 a.m. - A CNA transported the resident to the day room in preparation for lunch.
- 3/16/17 at 1:10 p.m. - The resident was lying on her back in her bed, and her eyes were closed. There was no music playing in the room.
- 3/16/17 at 4:30 p.m. - The resident was lying on her back in bed. Her eyes were open and her arms were reaching/grasping in the air. There was no music playing in the room.

A review of Resident #1's admission MDS assessment with an assessment reference date of 4/22/16 revealed the following activities as being very important to the resident: being

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around animals such as pets, keeping up with the news, and listening to music.

A review of the facility document entitled "Activities Assessment 3.0" dated 3/13/17 revealed, in part, the following: "Sight considerations: Moderately impaired, resident takes her glasses off, doesn't want to wear them...Resident awake all or most of the time: afternoon, evening...Preferred Activity Settings: day/activity room...General Activity Preferences -- adapted to resident's current abilities: music, watching TV...Hobbies and leisure activities during lifetime: Enjoys Mozart music, TV-animal plant, news, weather and The Voice music program, Loves cats and dogs, Liked to walk and be outdoors, used to ski when younger. Spending time with family."

A review of the clinical record for Resident #1 revealed the following note dated 12/14/16, written by OSM (other staff member) #4, the activities assistant: "[Resident #1]'s hearing is adequate, no use of devices. Vision is highly impaired, no use of glasses. Speech is clear and resident continues to yell out and is disruptive. Resident sometimes understands others and rarely makes self-understood. Resident presents alert/oriented to herself. Daughter is involved in her care and visits often. Resident spends most of her time in her room where she can watch TV and rest. The activity staff will offer social, sensory and recreational visits to maintain present level of functioning. Resident relies on the nursing staff for ADL (activities of daily living) care and medical needs."

A review of the comprehensive care plan for Resident #1 dated 4/15/16 and updated on

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F 248	Continued From page 4 3/13/17 revealed, in part, the following: "Resident has increased agitation and verbal combativeness with lack of attention to attend and participate in group activities at times...Encourage and assist to group activities, target - Pet therapy, music groups, going outdoors on patio as tolerated. Offer socialization through visits from family, friends, and volunteers. PROVIDE MUSIC FOR RESIDENT IN HER ROOM (facility's capitalization). Sit resident where she can't be disruptive to other residents or the activity while allowing resident to participate in groups." A review of the activity calendar for Resident #1 for January, February and March 2017 revealed, in part, the following: - January 2017: Only one activity highlighted during the whole month (Trivia at 10:00 a.m. on 1/16/17). The month included eight opportunities for pet therapy, and at least four activities called "Music Hour." The notes on the back of the calendar indicated Resident #1 was "passive/yelling out" on 1/16/17 (no time), "watching TV in room" on 1/18/17 (no time), "sleeping" on 1/19/17 (no time) and "tv in room" on 1/30/17 (no time). - February 2017 - Nine activities highlighted during the month (all were group activities except for 2/28/17, which was documented as "1:1." The month included eight opportunities for pet therapy, and at least four activities called "Music Hour." The notes on the back of the calendar indicated Resident #1 was "yelling out during group) on 2/1/17 (no time), Resident #1 received 1:1 visit on 2/6/17, Resident #1 was offered a 1:1 visit on 2/7/17 but spit her food out, and Resident #1 was visited in her room and the radio was turned on 2/28/17.	F 248		

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- March 2017 - One activity indicated between 3/1/17 and 3/15/17 (1:1 visit on 3/9/17). The month to date included four opportunities for pet therapy, and at least two activities called "Music Hour." The notes on the back of the calendar indicated Resident #1 was "yelling out" in her room with the television on at some point on 3/6/17.

On 3/16/17 at 11:45 a.m., OSM (other staff member) #4 was interviewed. She stated she was the primary activities staff member on Resident #1's unit in the mornings. When asked how resident activity participation is documented, she stated each resident has an individual activity calendar for each month. The facility staff highlights activities that residents are either offered and decline, or participate in. OSM #4 stated: "If a resident declines an activity, we write 'declined' on the calendar." OSM #4 was asked to provide the surveyor with a copy of Resident #1's activity records since 1/1/17.

On 3/16/17 at 3:00 p.m., OSM #4 returned to the surveyor and provided the requested activity records for Resident #1. She stated when Resident #1 was first admitted to the facility, she enjoyed socializing and group activities. She stated Resident #1 has declined in recent months, and now is more aggressive with her behaviors, and frequently yells out. OSM #4 stated: "We bring her into the group. Then if she is yelling and grabbing, we set her outside the group so she can still hear what is going on, but not be disruptive to others. If she keeps on yelling, we take her to her room and let her listen to TV or to music." She stated Resident #1 could not see the TV very well, but could hear it. She stated the resident had a CD player in her room

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for music. OSM #4 was informed of the above referenced observations of Resident #1 over the days of the surveyor. OSM #4 stated: "This morning, she was out in the dining room for breakfast. She became agitated. One of the CNAs offered to take her to her room." When asked if Resident #1 was offered the opportunity later to be a part of the group or to listen to the musical playing in the day room, OSM #4 stated: "No. We did not try that." She stated she was not aware that the resident's television did not have any sound coming from it or any music playing. OSM #4 stated: "I will always turn her music on." When asked if she documented this at any time, OSM #4 stated: "I don't always. Sometimes." She stated the whole activities staff is responsible for assessing the resident and developing the resident's care plan. She stated the whole facility staff is responsible for making sure the care plan is followed. When shown Resident #1's activity care plan, OSM #4 was asked if Resident #4's care plan was being followed, OSM #4 stated: "No. I can't say that it is." When asked if Resident #1 was receiving individualized, person-centered activities according to her dementia, behaviors, and assessments, OSM #4 stated: "No. I'm not sure how to do that. I am just one person."

On 3/16/17 at 3:20 p.m., OSM #5, the activities director, was interviewed. She provided the surveyor with current qualifications that meet the requirements for her position. She stated that when the activities staff performs assessments on the residents, they are "looking for what the residents want, what gives them joy." She stated the team turns the assessments, which are mostly documented on the MDS, into specific interventions on the care plan. When asked who

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is responsible for implementing the care plan, OSM #5 stated: "The activities team." When asked how activities fit into an individualized, person-centered plan of care for a resident with dementia who cannot verbalize her needs, OSM #5 stated: "Well, I know she has dementia. I know she likes music, and she likes presence - someone there with her. Yes, it looks like we could be doing a better job of implementing her program."

On 3/16/17 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional consultant, were informed of these concerns.

A review of the facility policy entitled "Activity Programs" revealed, in part, the following: "Activity programs designed to meet the needs of each resident are available on a daily basis. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs...Individualized and group activities are provided that...reflect the cultural and religious interests, hobbies, life experiences, and personal preferences of the residents."

No further information was provided prior to exit.

(1)"COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. "Progressive" means the disease gets worse over time." This information is taken from the website http://www.nhlbi.nih.gov/health/health-topics/topics/copd.

(2) "Bipolar disorder, also known as

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F 248	Continued From page 8 manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	F 248		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to follow professional standards for three of 24 residents in the survey sample, Resident #11, Resident #19 and Resident #2. 1. The facility staff failed to clarify with the orders with the physician, regarding a pacemaker for Resident #11 at the time of admission. 2. The facility staff failed to clarify orders with the physician, regarding a pacemaker for Resident #19 at the time of admission. 3. The facility staff failed to clarify orders with the physician, regarding a pacemaker for Resident #2 at the time of admission. The findings include:	F 281	**F281** **Corrective Action(s):** Resident #2, #11 and #19 have had their attending physician's notified that the facility staff failed to clarify the residents pace maker checks with the attending physician at time of admission. Resident #2, #11 and #19's Pace maker check orders have been reviewed and clarified. A Facility Incident & Accident Form was completed for these incidents. **Identification of Deficient Practices/Corrective Action(s):** All other residents with pace makers may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all residents with a pace maker to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified to clarify the pace maker check orders. An Incident & Accident form will be completed for each negative finding.	

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1. Resident #11 was admitted to the facility on 1/31/13 with diagnoses that included but were not limited to: pacemaker, diabetes, depression, arthritis and dementia.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/8/17 coded the resident as having short and long term memory problems and as moderately impaired for daily decision making. The resident was coded as requiring assistance for all activities of daily living.

Review of the resident's care plan initiated on 1/31/13 documented, "Problem/Need INABILITY TO PERFORM ADLS (activities of daily living) INDEPENDENTLY SECONDARY TO HTN (hypertension), PACEMAKER...Approaches MEDS (medications) PER ORDER, MONITOR VITAL SIGNS."

Review of the physician order sheet (POS) dated and signed 3/13/17 did not evidence documentation regarding what and or if any monitoring of Resident #11's pacemaker function should be completed.

Review of the March 2017 MAR (medication administration record) did not evidence documentation regarding what and or if any monitoring should be done of Resident #11's pacemaker function.

Review of the clinical record did not evidence a cardiology consult. Further review of the record did not evidence documentation that the pacemaker's functioning had been checked since the resident was admitted.

Systemic Change(s):
The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, clarifying, transcribing and administering physician ordered medications and treatments per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for following physician ordered medication and treatment orders.

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or ADON will review all new resident admission orders weekly to ensure any residents admitted with a Pace maker has the appropriate pace maker check orders written and clarified. Any negative findings will be corrected and clarified at the time of discovery. 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: 4/28/2017

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An interview was conducted on 3/16/17 at 12:40 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who had created the care plan for Resident #11, RN #1 stated she had. RN #1 was asked how staff knew how to care for a pacemaker. RN #1 stated, "If there are any signs and symptoms that are adverse they should call the doctor." When asked what symptoms they should observe for, RN #1 stated, that they should clarify it with the doctor. When asked who should clarify the pacemaker care, RN #1 stated, "Nursing. If I saw something missing I would clarify it."

An interview was conducted on 3/16/17 at 1:30 p.m. with LPN (licensed practical nurse) #4, the nurse caring for Resident #11. When asked how a resident with a pacemaker was monitored, LPN #4 stated, "It needs to be checked periodically depending on the cardiologist. It could be every three months or every six months. When asked if she had any residents with a pacemaker, LPN #4 stated, she did not. When informed that Resident #11 had a pacemaker LPN #4 did not respond.

On 3/16/17 at 5:15 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the findings. When asked what nursing standard the staff used, ASM #2 stated, "Lippincott."

An interview was conducted with LPN #5 on 3/17/17 at 9:15 a.m. LPN #5 was asked what symptoms staff look for in a resident with a pacemaker. LPN #5 stated, "Dizziness, syncope (fainting) and bradycardia (slow heart beat)." When asked what would staff do should these symptoms occurred, LPN #5 stated, "Call the doctor."

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An interview was conducted on 3/17/17 at 9:48 a.m. with ASM #3, the resident's physician. ASM #3 was asked about the process he follows when a resident was admitted to the facility with a pacemaker. ASM #3 stated, "Most residents are on demand pacemakers (1) and I talk with the family (about what they want to do.) If they're medically stable or asymptomatic don't need to check them. If they depend on the pacemaker we need to check it every three to six months." When asked how staff knew which residents depended on their pacemaker, ASM #3 stated, "We write it on the orders. I expect them to call for any symptoms but they expect me to write the order. I'm going to start a new process; it'll be on a separate paper to tell them what to do (with the pacemaker)."

A review of the facility policy titled "Pacemaker, Care of a Resident with a...." revealed, in part, the following documentation; "Monitoring. 5. Make sure the resident has a medical identification card that indicates he or she has a pacemaker. The medical record must contain this information as well. Documentation. 1. For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: a) The name, address and telephone number of the cardiologist; b. Type of pacemaker; c. Type of leads; d. Manufacturer and model; e. Serial number; f. Date of implant; and g. paced rate.

According to Lippincott Manual of Nursing Practice, 10th edition, page 356, "Follow-up 1. Make sure that the patient has a copy of ECG (electrocardiogram) tracing (according to facility policy) for future comparisons. Encourage patient

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	495261	A. BUILDING _____ B. WING _____	C 03/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NRSG AND REHAB	122 MORVEN PARK ROAD NW LEESBURG, VA 20176

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to have regular pacemaker checkups for monitoring function and integrity of pacemaker..."

(1) Demand pacemaker -- A demand pacemaker monitors your heart rhythm. It only sends electrical pulses to your heart if your heart is beating too slow or if it misses a beat. This information was obtained from: https://www.nhlbi.nih.gov/health/health-topics/topics/pace/howdoes

(2) Bradyarrhythmias -- Clinicians have long recognized the potentially serious manifestations of extreme bradycardia. However, even marked bradycardia can often be physiologic, and in the presence of impaired ventricular function may offer important compensatory hemodynamic effects. Disorders of the sinoatrial node producing bradycardia include failure of impulse formation, sinoatrial conduction block, concealed sinus-perinodal reentry, carotid sinus hypersensitivity and the constellation of brady- and tachyarrhythmias that compose the "sick sinus syndrome." This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/6826942

2. Resident #19 was admitted to the facility on 12/12/14 with diagnoses that included but were not limited to: pacemaker, high blood pressure, anxiety, anemia and kidney diseases.

The most recent MDS, a quarterly assessment, with an ARD of 3/13/17 coded the resident as having scored 5 out of 15 on the BIMS (brief interview for mental status) indicating that the resident was severely impaired cognitively. The resident was coded as requiring assistance with all activities of daily living.

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Review of Resident #19's care plan dated 12/12/14 documented, "Problem/Need INABILITY TO PERFORM ADLS INDEPENDENTLY SECONDARY TO ....PACEMAKER...Approaches MEDS (medications) PER ORDER, MONITOR VITAL SIGNS."

Review of the physician's history and physical dated 12/12/14 did not evidence documentation regarding the pacemaker.

Review of the March 2017 POS (physician order sheet) did not evidence documentation regarding the care and monitoring of the resident's pacemaker.

Review of the March 2017 MAR did not evidence documentation regarding the care and monitoring of the resident' pacemaker.

Review of the clinical record did not evidence documentation of a cardiology consult or that the pacemaker function had been checked.

An interview was conducted on 3/16/17 at 12:40 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who had created the care plan for Resident #19, RN #1 stated she had. When asked how staff knew how to care for a pacemaker, RN #1 stated, "If there are any signs and symptoms that are adverse they should call the doctor." When asked what symptoms they should observe for, RN #1 stated, that they should clarify it with the doctor. When asked who should clarify the pacemaker care, RN #1 stated, "Nursing. If I saw something missing I would clarify it."

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An interview was conducted on 3/16/17 at 1:30 p.m. with LPN (licensed practical nurse) #4, the nurse caring for Resident #19. When asked how a resident with a pacemaker was monitored, LPN #4 stated, "It needs to be checked periodically depending on the cardiologist. It could be every three months or every six months. When asked if she had any residents with a pacemaker, LPN #4 stated, she did not. When informed that Resident #19 had a pacemaker LPN #4 did not respond.

On 3/16/17 at 5:15 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the findings. When asked what nursing standard the staff used, ASM #2 stated, "Lippincott."

An interview was conducted with LPN #5 on 3/17/17 at 9:15 a.m. When asked what symptoms staff look for in a resident with a pacemaker, LPN #5 stated, "Dizziness, syncope (fainting) and bradycardia (slow heart beat)." When asked what staff would do should these symptoms occur, LPN #5 stated, "Call the doctor."

An interview was conducted on 3/17/17 at 9:48 a.m. with ASM #3, the resident's physician. ASM #3 was asked about the process he follows when a resident was admitted to the facility with a pacemaker. ASM #3 stated, "Most residents are on demand pacemakers and I talk with the family (about what they want to do.) If they're medically stable or asymptomatic don't need to check them. If they depend on the pacemaker we need to check it every three to six months." When asked how staff knew which residents depended on their pacemaker, ASM #3 stated, "We write it on the orders. I expect them to call for any symptoms but they expect me to write the order.

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I'm going to start a new process; it'll be on a separate paper to tell them what to do (with the pacemaker)."

No further information was provided prior to exit.

No further information was provided prior to the end of the survey process.

3. Resident #2 was admitted to the facility on 4/18/16 with a readmission on 8/12/16 with diagnoses that included, but were not limited to, high blood pressure, dementia, anxiety, depression, psychosis, and a pacemaker.

Resident #2's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/30/17. Resident #2 was coded on the BIMS (brief interview of mental status) as having a score of 10 out of a possible 15, indicating that Resident #2 is cognitively moderately impaired with daily decision making.

A review of Resident #2's clinical record revealed, in part, a comprehensive care plan dated 8/12/16 that revealed the following documentation; "Problem Onset: 6/9/2016. @ (at) RISK FOR CARDIAC COMPLICATIONS R/T (related to) CAD (coronary artery disease), HTN (hypertension), ANGINA PECTORIS (chest pain with exertion), PACEMAKER. Approaches: PACEMAKER CHECKS PER ORDER, ASSESS FOR IMPAIRED CARDIAC OUTPUT, DIFFICULTY BREATHING, CHANGE IN SKIN COLOR, LEVEL OF CONCIOUSNESS (sic)."

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Further review of Resident #2's clinical record did not reveal any physician notes, physician orders or nursing notes that addressed Resident #2's pacemaker.

On 3/16/17 at 9:20 a.m. LPN (licensed practical nurse) #1, a unit manager, was asked to provide any information regarding pacemaker orders and pacemaker checks for Resident #2.

On 3/16/17 at 12:50 p.m. an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 was asked if she was responsible for developing care plans, RN #1 stated that she was. RN #1 was asked how she determined what would be care planned. RN #1 stated that she would review the hospital records, nursing notes, physician notes and CAA (care area assessment) triggers and care plan accordingly. RN #1 was asked specifically about Resident #2's care plan and RN #1 was asked to review the care plan. RN #1 was asked why she had care planned for a pacemaker. RN #1 stated that she would have seen on the hospital records that Resident #2 had a pacemaker and care planned for it. RN #1 was asked to explain what "pacemaker checks per order" meant. RN #1 stated that the nursing staff should have a pacemaker check performed if the resident demonstrated signs and symptoms of pacemaker failure. RN #1 was asked what "order" she was referring to in the care plan. RN #1 stated, "There was no order, it is a generalized care plan to cue the nursing staff." RN #1 was asked if she was a floor nurse what this statement would mean to her. RN #1 stated, "If I read this as a nurse I would contact my physician and ask for an order regarding the pacemaker." RN #1 was asked if she verified that there was an order

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regarding the pacemaker when she wrote the entry "pacemaker checks per order." RN #1 stated, "This is standard practice for managing a resident with a pacemaker. If there was no order I would (as the MDS coordinator) bring this to nursing's attention so that they could obtain physician clarification and an order." RN #1 was asked whether or not she notified the nursing staff that there was no order. RN #1 stated that she did not.

On 3/16/17 at approximately 3:00 p.m. an interview was conducted with LPN #1, a unit manager. LPN #1 stated that she did not have any further documentation on Resident #2's pacemaker. LPN #1 was asked whether or not there should be orders provided for a pacemaker. LPN #1 stated, "Some people don't get checked. The families may bring in their own equipment to check and have a schedule. Some residents go out to their cardiologists." LPN #1 was asked if there were no discharge orders and no family members what would the nursing staff do regarding the pacemaker. LPN #1 stated, "It's up to the physician." LPN #1 was asked about Resident #2's pacemaker. LPN #1 stated, "She (Resident #2) has a son, they have a love/hate relationship. The son did not bring any pacemaker equipment." LPN #1 was asked whether or not the physician was contacted regarding pacemaker orders. LPN #1 stated she did not know.

On 3/16/17 at approximately 4:00 p.m. ASM (administrative staff member) #2, the director of nursing, provided a history and physical signed by a physician with no date of signature and a hospital discharge summary dated 4/9/16. Both documents had a fax date stamp of 3/16/17.

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ASM #2 was asked when the documents were received and she confirmed that she had just received them. ASM #2 was asked when the history and physical had been written. ASM #2 stated that she asked the physician to write it that afternoon. The history and physical signed by the physician documented, in part, the following; "Pacer check as needed if pt (patient) is symptomatic like dizziness or syncope (fainting)." ASM #2 stated that Resident #2's pacemaker had been checked when she was in the hospital. A review of the discharge summary provided regarding Resident #2's 4/9/16 admission revealed, in part, the following documentation; "Cardiac pacemaker placement for sick sinus syndrome (a cardiac dysrhythmia) July 2014." There was no documentation that stated Resident #2's pacemaker had been checked. ASM #2 was asked whether or not an order should have been obtained from the physician regarding care of Resident #2's pacemaker, ASM #2 stated yes. A policy was requested regarding obtaining orders and care of a resident with a pacemaker.

On 3/17/17 at 8:40 a.m. an interview was conducted with RN (registered nurse) #3. RN #3 was asked what she would do if she did not have orders on admission to manage a resident with a pacemaker. RN #3 stated, "It is important to know the rate that the pacemaker is set at, and what to do if the pacemaker fails." RN #3 was asked whether or not she would have a physician order for managing the pacemaker. RN #3 stated that she should. RN #3 was asked if she did not have an order what she would do. RN #3 stated she would call the physician and obtain an order.

On 3/17/17 at 9:55 a.m. an interview was conducted with ASM #3, the medical doctor.

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ASM #3 was asked what his process was when a resident was admitted to the facility with an existing pacemaker. ASM #3 stated, "It depends on the patient as to how we manage the pacemaker, how often it should be checked." ASM #3 was asked how nursing would know what to do. ASM #3 stated, "I would write an order and indicate when it (the pacemaker) should be checked and that if the resident was having cardiac symptoms then the pacemaker should be checked and an appointment made to cardiology." ASM #3 was asked what the nursing staff should do if there was no order in the clinical record. ASM #3 stated, "It is up to the nurse to contact the physician. The nursing staff depends on the physician to write the order. It should be in the orders." ASM #3 was asked specifically about Resident #2. ASM #3 stated that there should have been an order written by him regarding the pacemaker.

A review of the facility policy titled "Pacemaker, Care of a Resident with a...." revealed, in part, the following documentation; "Monitoring. 5. Make sure the resident has a medical identification card that indicates he or she has a pacemaker. The medical record must contain this information as well. Documentation. 1. For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: a) The name, address and telephone number of the cardiologist; b. Type of pacemaker; c. Type of leads; d. Manufacturer and model; e. Serial number; f. Date of implant; and g. paced rate.

F282
Corrective Action(s):
Resident #1's attending physician has been notified that facility staff failed to provide activities as outlined on Resident #1's comprehensive care plan. A facility incident and accident form has been completed for this incident.

F 282 SS=D 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN — F 282

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F 282	Continued From page 20 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow the written plan of care for one of 26 residents in the survey sample, Resident #1. The facility failed to provide activities according to Resident #1's comprehensive care plan on 3/15/17 and 3/16/17. The findings include: Resident #1 was admitted to the facility on 4/15/16 with diagnoses including, but not limited to: Alzheimer's disease, chronic obstructive pulmonary disease (1), bipolar disorder, anxiety and depression. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 12/20/16, Resident #1 was coded as having both short term and long term memory difficulties, and as being moderately impaired for making daily decisions. She was coded as requiring the extensive assistance of two staff members for bed mobility, and as being dependent on staff for transfers and for locomotion around the unit. She was coded as being highly visually impaired. The following observations were made of	F 282	**Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The Activity Director and/or Activity Assistants will conduct a 100% review of all resident activity care plans to identify residents at risk. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physician will be notified of each incident. **Systemic Change(s):** The facility policy and procedure for Activities has been reviewed and no revisions are warranted at this time. The Activity Director will inservice all activity staff and Nursing staff on the requirement to provide resident specific activities daily per the resident specific care plan. **Monitoring:** The Activity Director is responsible for maintaining compliance. The Activity Director and/or Activity Assistant will perform reviews of the residents Activity Care plan and activity calendars coinciding with the Care plan schedule to monitor for compliance. Any/all negative findings will be corrected at time of discovery and revisions will be made to the care plan as needed. Aggregate findings of these reviews 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: 4/28/2017**	

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Resident #1 during the survey:
- 3/15/17 at 11:30 a.m. - The resident was reclined in her chair in the day room, yelling intermittently. No formal activity was taking place at this time.
- 3/15/17 at 2:00 p.m. - The resident was reclined in her chair in her room. The chair faced the television, which was in the far corner of the room. The resident's back was to the hallway. The television did not have sound coming from it.
- 3/15/17 at 5:10 p.m. - The resident was lying on her back in bed, with her eyes open. Her arms were reaching/grasping in the air. There was no television on or music playing in the room.
- 3/16/17 at 7:45 a.m. - The resident was reclined in her chair, and a CNA (certified nursing assistant) was pushing the chair into the day room. Resident #1 was yelling intermittently.
- 3/16/17 at 9:10 a.m. - The resident was reclined in her chair in her room, and her eyes were closed. The chair faced the television, which was in the far corner of the room. The resident's back was to the hallway. The television did not have sound coming from it.
- 3/16/17 at 10:15 a.m. - The resident was reclined in her chair in her room, and her eyes were closed. The chair faced the television, which was in the far corner of the room. The resident's back was to the hallway. The television did not have sound coming from it. In the unit's dayroom, a word game activity was occurring. In the unit's dining room, a movie musical was being shown on the television
- 3/16/17 at 10:45 a.m. - The resident was reclined in her chair in her room, and her eyes were open. The chair faced the television, which was in the far corner of the room. The resident's back was to the hallway. The television did not have sound coming from it. In the unit's

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dayroom, the television was tuned to a soothing music station. In the unit's dining room, a movie musical was being shown on the television.
- 3/16/17 at 11:35 a.m. - A CNA transported the resident to the day room in preparation for lunch.
- 3/16/17 at 1:10 p.m. - The resident was lying on her back in her bed, and her eyes were closed. There was no music playing in the room.
- 3/16/17 at 4:30 p.m. - The resident was lying on her back in bed. Her eyes were open and her arms were reaching/grasping in the air. There was no music playing in the room.

A review of Resident #1's admission MDS with an assessment reference date of 4/22/16 revealed the following activities as being very important to the resident: being around animals such as pets, keeping up with the news, and listening to music.

A review of the facility document entitled "Activities Assessment 3.0" dated 3/13/17 revealed, in part, the following: "Sight considerations: Moderately impaired, resident takes her glasses off, doesn't want to wear them...Resident awake all or most of the time: afternoon, evening...Preferred Activity Settings: day/activity room...General Activity Preferences - - adapted to resident's current abilities: music, watching TV...Hobbies and leisure activities during lifetime: Enjoys Mozart music, TV-animal plant, news, weather and The Voice music program, Loves cats and dogs, Liked to walk and be outdoors, used to ski when younger. Spending time with family."

A review of the clinical record for Resident #1 revealed the following note dated 12/14/16 and written by OSM (other staff member) #4, the activities assistant: "[Resident #1]'s hearing is

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adequate, no use of devices. Vision is highly impaired, no use of glasses. Speech is clear and resident continues to yell out and is disruptive. Resident sometimes understands others and rarely makes self understood. Resident presents alert/oriented to herself. Daughter is involved in her care and visits often. Resident spends most of her time in her room where she can watch TV and rest. The activity staff will offer social, sensory and recreational visits to maintain present level of functioning. Resident relies on the nursing staff for ADL (activities of daily living) care and medical needs."

A review of the comprehensive care plan for Resident #1 dated 4/15/16 and updated 3/13/17 revealed, in part, the following: "Resident has increased agitation and verbal combativeness with lack of attention to attend and participate in group activities at times...Encourage and assist to group activities, target - Pet therapy, music groups, going outdoors on patio as tolerated. Offer socialization through visits from family, friends, and volunteers. PROVIDE MUSIC FOR RESIDENT IN HER ROOM (facility's capitalization). Sit resident where she can't be disruptive to other residents or the activity while allowing resident to participate in groups."

A review of the activity calendar for Resident #1 for January, February and March 2017 revealed, in part, the following:
- January 2017: Only one activity highlighted during the whole month (Trivia at 10:00 a.m. on 1/16/17). The month included eight opportunities for pet therapy, and at least four activities called "Music Hour." The notes on the back of the calendar indicated Resident #1 was "passive/yelling out" on 1/16/17 (no time),

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"watching TV in room" on 1/18/17 (no time), "sleeping" on 1/19/17 (no time) and "tv in room" on 1/30/17 (no time).
- February 2017 - Nine activities highlighted during the month (all were group activities except for 2/28/17, which was documented as "1:1." The month included eight opportunities for pet therapy, and at least four activities called "Music Hour." The notes on the back of the calendar indicated Resident #1 was "yelling out during group) on 2/1/17 (no time), Resident #1 received 1:1 visit on 2/6/17, Resident #1 was offered a 1:1 visit on 2/7/17 but spit her food out, and Resident #1 was visited in her room and the radio was turned on 2/28/17.
- March 2017 - One activity indicated between 3/1/17 and 3/15/17 (1:1 visit on 3/9/17). The month to date included four opportunities for pet therapy, and at least two activities called "Music Hour." The notes on the back of the calendar indicated Resident #1 was "yelling out" in her room with the television on at some point on 3/6/17.

On 3/16/17 at 11:45 a.m., OSM #4 was interviewed. She stated she was the primary activities staff member on Resident #1's unit in the mornings. When asked how resident activity participation is documented, she stated each resident has an individual activity calendar for each month. The facility staff highlights activities that residents are either offered and decline, or participate in. OSM #4 stated: "If a resident declines an activity, we write 'declined' on the calendar." OSM #4 was asked to provide the surveyor with a copy of Resident #1's activity records since 1/1/17.

On 3/16/17 at 12:50 p.m., RN (registered nurse)

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#1, the MDS coordinator, was interviewed. When asked if she develops the activity care plan for residents, she stated: "No, the activities team does that." When asked who is responsible for implementing a resident's plan of care, she stated: "Everyone."

On 3/16/17 at 3:00 p.m., OSM #4 returned to the surveyor and provided the requested activity records for Resident #1. She stated when Resident #1 was first admitted to the facility, she enjoyed socializing and group activities. She stated Resident #1 has declined in recent months, and now is more aggressive with her behaviors, and frequently yells out. OSM #4 stated: "We bring her into the group. Then if she is yelling and grabbing, we set her outside the group so she can still hear what is going on, but not be disruptive to others. If she keeps on yelling, we take her to her room and let her listen to TV or to music." She stated Resident #1 could not see the TV very well, but could hear it. She stated the resident had a CD player in her room for music. OSM #4 was informed of the above referenced observations of Resident #1 over the days of the surveyor. OSM #4 stated: "This morning, she was out in the dining room for breakfast. She became agitated. One of the CNAs offered to take her to her room." When asked if Resident #1 was offered the opportunity later to be a part of the group or to listen to the musical playing in the day room, OSM #4 stated: "No. We did not try that." She stated she was not aware that the resident's television did not have any sound coming from it or any music playing. OSM #4 stated: "I will always turn her music on." When asked if she documented this at any time, OSM #4 stated: "I don't always. Sometimes." She stated the whole activities staff

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is responsible for assessing the resident and developing the resident's care plan. She stated the whole facility staff is responsible for making sure the care plan is followed. When shown Resident #1's activity care plan, OSM #4 was asked if Resident #4's care plan was being followed, OSM #4 stated: "No. I can't say that it is." When asked if Resident #1 was receiving individualized, person-centered activities according to her dementia, behaviors, and assessments, she stated: "No. I'm not sure how to do that. I am just one person."

On 3/16/17 at 3:20 p.m., OSM #5, the activities director, was interviewed. She provided the surveyor with current qualifications that meet the requirements for her position. She stated that when the activities staff performs assessments on the residents, they are "looking for what the residents want, what gives them joy." She stated the team turns the assessments, which are mostly documented on the MDS, into specific interventions on the care plan. When asked who is responsible for implementing the care plan, OSM #5 stated: "The activities team." When asked how activities fit into an individualized, person-centered plan of care for a resident with dementia who cannot verbalize her needs, OSM #5 stated: "Well, I know she has dementia. I know she likes music, and she likes presence - someone there with her. Yes, it looks like we could be doing a better job of implementing her program."

On 3/16/17 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional consultant, were informed of these concerns.

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F 282	Continued From page 27 A review of the facility policy entitled "Using the Care Plan" revealed, in part, the following: "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident...Completed care plans are placed in the resident's chart and/or in a 3-ring binder located at the appropriate nurses' station...Documentation must be consistent with the resident's care plan." No further information was provided prior to exit. (1)"COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. "Progressive" means the disease gets worse over time." This information is taken from the website http://www.nhlbi.nih.gov/health/health-topics/topics/copd. (2) "Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	F 282		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 371	F 371 Corrective Action(s): The two unopened and expired containers of potato salad and coleslaw identified in the walk-in refrigerator during the initial kitchen tour was immediately removed and disposed of. A facility Incident and Accident form was completed for this incident.	

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F 371	Continued From page 28 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review it was determined that facility staff failed to store food in a safe and sanitary manner. The facility staff failed to discard expired potato salad and cole slaw. The findings include: An observation of the kitchen was made on 3/14/17 at 11:40 a.m. with OSM (other staff member) #1, the food service manager. In the walk in refrigerator there was a seven pound unopened container of potato salad with an expiration date of 3/7/17 and a seven pound unopened contained of cole slaw with an expiration date of 3/10/17. OSM #1 immediately removed the containers from the shelves and	F 371	**Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician will inspect the walk-in refrigerator and freezer to identify any negative findings. The walk-in freezers and refrigerators in the kitchen will be monitored daily for proper storage of food items. Any expired food or unlabeled or undated food items identified in the kitchen freezers, refrigerators or dry storage area will be removed and disposed of at time of discovery. A facility Incident and Accident form will be completed for each negative finding identified. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will inservice the Dietary Manager and dietary staff on the proper preparing, storing and distribution of food under sanitary conditions, as well as the policy and procedure for proper sanitation and hand washing. **Monitoring:** The Dietary Manager is responsible for maintaining compliance. The Dietary manager will complete the Dietary Food storage audit tool daily to monitor for compliance. Any negative findings will be corrected at time of discovery 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: 4/28/2017**	

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F 371	Continued From page 29 disposed of them. When asked who checks the refrigerator for expired items, OSM #1 stated, "I check it but I don't know how it happened." Review of the facility's policy titled, "Food Storage Guidelines For Consumers" documented, "Other foods such as unbaked breads, are marked with an "expiration" or "use by date," which means the product should not be consumed after that date." On 3/16/17 at 5:15 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the findings. No further information was provided prior to exit.	F 371		
F 385 SS=D	483.30(a)(1)(2) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN §483.30(a) Physician Supervision. The facility must ensure that-- (1) The medical care of each resident is supervised by a physician; and (2) Another physician supervises the medical care of residents when their attending physician is unavailable. 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 provide physician supervision for three of 26 residents in the survey sample, Resident #11, Resident #19 and Resident #2. 1. The facility staff failed to provide orders for the	F 385	**F385** **Corrective Action(s):** The attending physicians for Residents #2, #11 and #15 have reviewed and clarifled the orders for Pace Maker checks to be obtained. A facility Incident & Accident forms has been completed for these incidents. **Identifllcation of Deficient Practices/Corrective Action(s):** All residents with Pace makers may have been affected affected. A 100% review of all residents with Pace makers will be completed to identify residents at risk. All negative findings will be corrected at time of discovery and their attending physician will be contacted to review and revise the pace maker check order. A Facility Incident & Accident form will be completed for each incident identified.	

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care of Resident #11's pacemaker at the time of admission.

2. The facility staff failed to provide orders for the care of Resident #19's pacemaker at the time of admission.

3. The physician failed to provide an order for the management of Resident #2's pacemaker at the time of admission.

The findings include:

1. Resident #11 was admitted to the facility on 1/31/13 with diagnoses that included but were not limited to: pacemaker, diabetes, depression, arthritis and dementia.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/8/17 coded the resident as having short and long term memory problems and as moderately impaired for daily decision making. The resident was coded as requiring assistance for all activities of daily living.

Review of the resident's care plan initiated on 1/31/13 documented, "Problem/Need INABILITY TO PERFORM ADLS (activities of daily living) INDEPENDENTLY SECONDARY TO HTN (hypertension), PACEMAKER...Approaches MEDS (medications) PER ORDER, MONITOR VITAL SIGNS."

Review of the physician order sheet (POS) dated and signed 3/13/17 did not evidence documentation regarding what and or if any monitoring of Resident #11's pacemaker function should be completed.

Systemic Change(s):
The Medical Director and attending Physicians have been inserviced by the administrator and/or DON on the current OLC regulations regarding physician services and coverage. Licensed staff will be inserviced by the administrator and/or DON on the communication and action to take if the physician is not timely with reviewing admission orders and/or needs to clarify resident specific orders and treatments upon admission per facility Policy & Procedure and physician standing orders.

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or ADON will review all new resident admission orders weekly to ensure any residents admitted with a Pace maker has the appropriate pace maker check orders written and clarified. Any negative findings will be corrected and clarified at the time of discovery. 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: 4/28/2017

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Review of the March 2017 MAR (medication administration record) did not evidence of documentation regarding what and or if any monitoring of Resident #11's pacemaker function should be completed.

Review of the clinical record did not evidence a cardiology consult. Further review of the record did not evidence documentation that the pacemaker's functioning had been checked since the resident was admitted.

An interview was conducted on 3/16/17 at 12:40 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who had created the care plan for Resident #11, RN #1 stated she had. When asked how staff knew how to care for a pacemaker, RN #1 stated, "If there are any signs and symptoms that are adverse they should call the doctor." When asked what symptoms they should observe for, RN #1 stated, that they should clarify it with the doctor. When asked who should clarify the pacemaker care, RN #1 stated, "Nursing. If I saw something missing I would clarify it."

An interview was conducted on 3/16/17 at 1:30 p.m. with LPN (licensed practical nurse) #4, the nurse caring for Resident #11. When asked how a resident with a pacemaker was monitored, LPN #4 stated, "It needs to be checked periodically depending on the cardiologist. It could be every three months or every six months. When asked if she had any residents with a pacemaker, LPN #4 stated, she did not. When informed that Resident #11 had a pacemaker LPN #4 did not respond.

On 3/16/17 at 5:15 p.m. ASM (administrative staff

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member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the findings.

An interview was conducted with LPN #5 on 3/17/17 at 9:15 a.m. When asked what symptoms staff look for in a resident with a pacemaker, LPN #5 stated, "Dizziness, syncope (fainting) and bradycardia (slow heart beat)." When asked what staff would do should these symptoms occur, LPN #5 stated, "Call the doctor."

An interview was conducted on 3/17/17 at 9:48 a.m. with ASM #3, the resident's physician. ASM #3 was asked about the process he follows when a resident was admitted with a pacemaker. ASM #3 stated, "Most residents are on demand pacemakers (1) and I talk with the family (about what they want to do.) If they're medically stable or symptomatic don't need to check them. If they depend on the pacemaker we need to check it every three to six months." When asked how staff knew which residents depended on their pacemaker, ASM #3 stated, "We write it on the orders. I expect them to call for any symptoms but they expect me to write the order. I'm going to start a new process; it'll be on a separate paper to tell them what to do (with the pacemaker)."

Review of the facility's policy titled, "Pacemaker, Care of a Resident with a" documented, "Monitoring 1. Monitor the resident for pacemaker failure by monitoring the signs and symptoms of bradyarrhythmias (2)....3. The pacemaker battery will be monitored remotely through the telephone or an internet connection....Documentation 1. For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification are upon admission: a.

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The name, address and telephone number of the cardiologist; b. Type of pacemaker; c. Type of leads; d. Manufacturer and model; e. Serial number; f. Date of implant; and G. Paced rate."

No further information was obtained prior to exit.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

(1) Demand pacemaker -- A demand pacemaker monitors your heart rhythm. It only sends electrical pulses to your heart if your heart is beating too slow or if it misses a beat. This information was obtained from: https://www.nhlbi.nih.gov/health/health-topics/topics/pace/howdoes

(2) Bradyarrhythmias -- Clinicians have long recognized the potentially serious manifestations of extreme bradycardia. However, even marked bradycardia can often be physiologic, and in the presence of impaired ventricular function may offer important compensatory hemodynamic effects. Disorders of the sinoatrial node producing bradycardia include failure of impulse formation, sinoatrial conduction block, concealed sinus-perinodal reentry, carotid sinus hypersensitivity and the constellation of brady- and tachyarrhythmias that compose the "sick sinus syndrome." This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/6826942

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2. Resident #19 was admitted to the facility on 12/12/14 with diagnoses that included but were not limited to: pacemaker, high blood pressure, anxiety, anemia and kidney diseases.

The most recent MDS, a quarterly assessment, with an ARD of 3/13/17 coded the resident as having scored 5 out of 15 on the BIMS (brief interview for mental status) indicating that the resident was severely impaired cognitively. The resident was coded as requiring assistance with all activities of daily living.

Review of Resident #19's care plan dated 12/12/14 documented, "Problem/Need INABILITY TO PERFORM ADLS INDEPENDENTLY SECONDARY TO ....PACEMAKER...Approaches MEDS PER ORDER, MONITOR VITAL SIGNS."

Review of the physician's history and physical dated 12/12/14 did not evidence documentation regarding the pacemaker.

Review of the March 2017 physician orders did not evidence documentation regarding the care and monitoring of the resident's pacemaker.

Review of the March 2017 MAR did not evidence documentation regarding the care and monitoring of the resident' pacemaker.

Review of the clinical record did not evidence documentation of a cardiology consult or that the pacemaker function had been checked.

An interview was conducted on 3/16/17 at 12:40 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who had created the care plan for Resident #19, RN #1 stated she

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had. When asked how staff knew how to care for a pacemaker, RN #1 stated, "If there are any signs and symptoms that are adverse they should call the doctor." When asked what symptoms they should observe for, RN #1 stated, that they should clarify it with the doctor. When asked who should clarify the pacemaker care, RN #1 stated, "Nursing. If I saw something missing I would clarify it."

An interview was conducted on 3/16/17 at 1:30 p.m. with LPN (licensed practical nurse) #4, the nurse caring for Resident #19. When asked how a resident with a pacemaker was monitored, LPN #4 stated, "It needs to be checked periodically depending on the cardiologist. It could be every three months or every six months. When asked if she had any residents with a pacemaker, LPN #4 stated, she did not. When informed that Resident #19 had a pacemaker LPN #4 did not respond.

On 3/16/17 at 5:15 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the findings.

An interview was conducted with LPN #5 on 3/17/17 at 9:15 a.m. When asked what symptoms staff look for in a resident with a pacemaker, LPN #5 stated, "Dizziness, syncope (fainting) and bradycardia (slow heart beat)." When asked what staff would do should these symptoms occur, LPN #5 stated, "Call the doctor."

An interview was conducted on 3/17/17 at 9:48 a.m. with ASM #3, the resident's physician. ASM #3 was asked the process he follows when a resident was admitted with a pacemaker. ASM #3 stated, "Most residents are on demand

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pacemakers (1) and I talk with the family (about what they want to do.) If they're medically stable or asymptomatic don't need to check them. If they depend on the pacemaker we need to check it every three to six months." When asked how staff knew which residents depended on their pacemaker, ASM #3 stated, "We write it on the orders. I expect them to call for any symptoms but they expect me to write the order. I'm going to start a new process; it'll be on a separate paper to tell them what to do (with the pacemaker)."

No further information was provided prior to exit.

3. Resident #2 was admitted to the facility on 4/18/16 with a readmission on 8/12/16 with diagnoses that included, but were not limited to, high blood pressure, dementia, anxiety, Depression, psychosis, and a pacemaker.

Resident #2's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/30/17. Resident #2 was coded on the BIMS (brief interview of mental status) as having a score of 10 out of a possible 15, indicating that Resident #2 is cognitively moderately impaired with daily decision making.

A review of Resident #2's clinical record revealed, in part, a comprehensive care plan dated 8/12/16 that revealed the following documentation; "Problem Onset: 6/9/2016. @ (at) RISK FOR CARDIAC COMPLICATIONS R/T (related to) CAD (coronary artery disease), HTN (hypertension), ANGINA PECTORIS (chest pain with exertion), PACEMAKER. Approaches: PACEMAKER CHECKS PER ORDER, ASSESS FOR IMPAIRED CARDIAC OUTPUT, DIFFICULTY BREATHING, CHANGE IN SKIN

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Further review of Resident #2's clinical record did not reveal any physician notes, physician orders or nursing notes that addressed Resident #2's pacemaker.

On 3/16/17 at 9:20 a.m. LPN (licensed practical nurse) #1, a unit manager, was asked to provide any information regarding pacemaker orders and pacemaker checks for Resident #2.

On 3/16/17 at 12:50 p.m. an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 was asked if she was responsible for developing care plans, RN #1 stated that she was. RN #1 was asked how she determined what would be care planned. RN #1 stated that she would review the hospital records, nursing notes, physician notes and CAA (care area assessment) triggers and care plan accordingly. RN #1 was asked specifically about Resident #2's care plan and RN #1 was asked to review the care plan. RN #1 was asked why she had care planned for a pacemaker. RN #1 stated that she would have seen on the hospital records that Resident #2 had a pacemaker and care planned for it. RN #1 was asked to explain what "pacemaker checks per order" meant. RN #1 stated that the nursing staff should have a pacemaker check performed if the resident demonstrated signs and symptoms of pacemaker failure. RN #1 was asked what "order" she was referring to in the care plan. RN #1 stated, "There was no order, it is a generalized care plan to cue the nursing staff." RN #1 was asked if she was a floor nurse what this statement would mean to her. RN #1 stated, "If I read this as a nurse I would contact my physician and ask for

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an order regarding the pacemaker." RN #1 was asked if she verified that there was an order regarding the pacemaker when she wrote the entry "pacemaker checks per order." RN #1 stated, "This is standard practice for managing a resident with a pacemaker. If there was no order I would (as the MDS coordinator) bring this to nursing's attention so that they could obtain physician clarification and an order." RN #1 was asked whether or not she notified the nursing staff that there was no order. RN #1 stated that she did not.

On 3/16/17 at approximately 3:00 p.m. an interview was conducted with LPN (licensed practical nurse) #1, a unit manager. LPN #1 stated that she did not have any further documentation on Resident #2's pacemaker. LPN #1 was asked whether or not there should be orders provided for a pacemaker. LPN #1 stated, "Some people don't get checked. The families may bring in their own equipment to check and have a schedule. Some residents go out to their cardiologists." LPN #1 was asked if there were no discharge orders and no family members what would the nursing staff do regarding the pacemaker. LPN #1 stated, "It's up to the physician." LPN #1 was asked about Resident #2's pacemaker. LPN #1 stated, "She (Resident #2) has a son, they have a love/hate relationship. The son did not bring any pacemaker equipment." LPN #1 was asked whether or not the physician was contacted regarding pacemaker orders. LPN #1 stated she did not know.

On 3/16/17 at approximately 4:00 p.m. ASM (administrative staff member) #2, the director of nursing, provided a history and physical signed by

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a physician with no date of signature and a hospital discharge summary dated 4/9/16. Both documents had a fax date stamp of 3/16/17. ASM #2 was asked when the documents were received and she confirmed that she had just received them. ASM #2 was asked when the history and physical had been written. ASM #2 stated that she asked the physician to write it that afternoon. The history and physical signed by the physician documented, in part, the following; "Pacer check as needed if pt (patient) is symptomatic like dizziness or syncope (fainting)." ASM #2 stated that Resident #2's pacemaker had been checked when she was in the hospital. A review of the discharge summary provided regarding Resident #2's 4/9/16 admission revealed, in part, the following documentation; "Cardiac pacemaker placement for sick sinus syndrome (a cardiac dysrhythmia) July 2014." There was no documentation that stated Resident #2's pacemaker had been checked. ASM #2 was asked whether or not an order should have been obtained from the physician regarding care of Resident #2's pacemaker, ASM #2 stated yes. A policy was requested regarding obtaining orders and care of a resident with a pacemaker.

On 3/17/17 at 8:40 a.m. an interview was conducted with RN (registered nurse) #3. RN #3 was asked what she would do if she did not have orders on admission to manage a resident with a pacemaker. RN #3 stated, "It is important to know the rate that the pacemaker is set at, and what to do if the pacemaker fails." RN #3 was asked whether or not she would have a physician order for managing the pacemaker, RN #3 stated that she should. RN #3 was asked if she did not have an order what she would do. RN #3 stated she would call the physician and obtain an order.

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On 3/17/17 at 9:55 a.m. an interview was conducted with ASM #3, the medical doctor. ASM #3 was asked what his process was when a resident was admitted to the facility with an existing pacemaker. ASM #3 stated, "It depends on the patient as to how we manage the pacemaker, how often it should be checked." ASM #3 was asked how nursing would know what to do. ASM #3 stated, "I would write an order and indicate when it (the pacemaker) should be checked and that if the resident was having cardiac symptoms then the pacemaker should be checked and an appointment made to cardiology." ASM #3 was asked what the nursing staff do if there was no order in the clinical record. ASM #3 stated, "It is up to the nurse to contact the physician. The nursing staff depends on the physician to write the order. It should be in the orders." ASM #3 was asked specifically about Resident #2. ASM #3 stated that there should have been an order written by him regarding the pacemaker.

A review of the facility policy titled "Pacemaker, Care of a Resident with a...." revealed, in part, the following documentation; "Monitoring. 5. Make sure the resident has a medical identification card that indicates he or she has a pacemaker. The medical record must contain this information as well. Documentation. 1. For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: a) The name, address and telephone number of the cardiologist; b. Type of pacemaker; c. Type of leads; d. Manufacturer and model; e. Serial number; f. Date of implant; and g. paced rate.

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F 385	Continued From page 41 No further information was provided prior to the end of the survey process.	F 385		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a	F 441	**F 441** **Corrective Action(s):** The medical director was notified that the facility failed to implement a comprehensive infection control program and failed to accurately complete infection control tracking logs. A facility Incident & Accident form has been completed for each of these incidents. The attending physicians for Residents #16 & #17 was notified that the facility failed to initiate isolation precautions while be treated for scabies The attending physician for Resident #16 was notified that a C.N.A. staff member failed to wash her hands prior to leaving the residents room. C.N.A. #4 has been inserviced by the DON on the proper contact isolation procedures and hand washing to be utilized when assisting residents on isolation precautions The attending physician for Resident #16 was notified that RN #5 failed to appropriately apply the yellow isolation gown prior to delivering care in the resident's rooms. RN #5 has been inserviced by the DON on the proper contact isolation procedures and the proper application of the Personal Protective Equipment to be utilized when assisting residents on isolation precautions	

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resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which 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; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a complete infection prevention and control program as evidenced by failure to include residents being treated for an infectious condition on the infection control tracking logs; and failed follow infection control procedures for two of 26

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents may have potentially been affected. A 100% review of all residents with infections will be conducted to identify whether the infection requires isolation precautions and if it was a community acquired or a nosocomial infection. All identified infections will be listed on the infection control tracking logs to monitor for trends, improvement, last culture with organism (if any) and to prevent and control the development of infections in the facility. Any/all negative findings related to isolation precautions and infection control tracking and trending will be corrected at time of discovery and a facility Incident & Accident form will be completed.

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residents in the survey sample, Resident #s 17, and 16.

1. The facility staff failed to include residents being treated for suspected scabies (Scabies is an itchy skin condition caused by the microscopic mite Sarcoptes scabi (1)) on their infection control log.

2. The facility staff failed to follow infection control policies and procedures and initiate contact isolation precautions when caring for Resident #17 while being treated for an infectious / contagious condition, scabies.

3a. The facility staff failed to follow infection control policies and procedures and initiate contact isolation precautions when caring for Resident #16 while being treated for an infectious / contagious condition, scabies.

b. The Facility staff failed to sanitize their hands after caring for a resident in isolation, Resident #16.

c. The facility staff failed to wear an isolation gown properly while caring for a resident in isolation, Resident #16.

The findings include;

1. The facility staff failed to include residents being treated for suspected scabies [1] (a contagious condition caused by a mite) on their infection control log.

A review of the facility infection control log did not reveal the treatment of residents in the facility for suspected infestation of scabies, a highly

Systemic Change(s):
The facility Infection Control policy and procedure has been reviewed and no changes are warranted at this time. The DON will be inserviced by the Regional Nurse Consultant on the facility's infection control policy and procedure and the infection tracking logs for maintaining proper infection control standards and prevention in the facility. All staff will be inserviced by the DON and/or Regional Nurse Consultant on the infection Control Policy to include the standard for isolation precautions, proper application and removal of PPE and hand washing to prevent the spread or infections.

Monitoring:
The DON is responsible for maintaining compliance. The facility has an infection control tracking log for monitoring and tracking infections to maintain compliance. The DON will review the infection control tracking log weekly and review/report all findings to the Risk Management Committee for review and recommendations. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure.
Compliance Date: 4/28/2017

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contagious condition caused by a microscopic mite. The infection control log identified only one of three current residents in the facility being treated for scabies as having a skin condition.

On 3/17/17 at 9:30 a.m. an interview was conducted with RN (registered nurse) #6, the infection control nurse. RN #6 was asked to describe her role as the infection control nurse. RN #6 stated that she was responsible for tracking/trending infections and to report any trends of infections. RN #6 further stated that she would follow up on anything appearing "out of the ordinary." RN #6 was asked to provide examples of "infections" that she would be concerned with. RN #6 stated, "C-Diff (clostridium difficile) (a bacterium that causes diarrhea [2]), MRSA (Methicillin-resistant Staphylococcus aureus) (a staph infection that is resistant to several common antibiotics [3]), and any bacterial or viral rash with an unknown etiology." RN #6 was asked what would be done with any of these types of conditions to mitigate the spread of the infection among other residents in the facility and/or staff. RN #6 stated, "Hand washing and isolation." RN #6 was asked if she would need a definitive diagnosis of any condition requiring isolation prior to implementing contact isolation precautions. RN #6 stated, "A condition we have not recognized, but has the potential to spread (among the residents) we would start contact isolation." RN #6 was asked at what point when trending from the infection control log she would be concerned with an outbreak. RN #6 stated, "If I see the infection in more than one person there is the potential." RN #6 was asked how she obtains her information for the infection control log. RN #6 stated that she obtains the information from the 24 hour report that the

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nurses do each day and from any new orders to treat an infection. RN #6 was asked how she utilized the information gathered on the infection control log. RN #6 stated, "The information can be sorted and gives (us) the ability to analyze what is happening in the facility as it relates to infections." RN #6 was asked whether or not scabies would be a condition that should be reflected on the infection control log. RN #6 stated that it would be reflected as a skin condition. At this point in time RN #6 was asked to review the infection control log for the residents in the facility currently receiving treatment for scabies, (Resident #s 15, 16 and 17). RN #6 reviewed the log and stated that Residents #16 and 17 were not on the infection control log. RN #6 stated that Resident #15 was on the log; the entry date was 2/23/17 and was documented as "resolved". RN #6 was asked if the resident was not on the log how were the incidents of infection tracked and trended. RN #6 stated, "From the 24 hour report and nursing notes." RN #6 was asked how the 24 hour reports translate to surveillance of a possible outbreak. RN #6 stated, "The information is gathered and several people are looking at it, the DON (director of nursing), and the ADON (assistant director of nursing)." RN #6 was asked who was acting on the information gathered from the 24 hour report and the nurse's notes. RN #6 stated, "It is acted on as a team, from top to bottom." RN #6 stated, "The information is conveyed. The infection control log is more for our monthly review, for QA (quality assurance). This (the infection control log) is not our surveillance tool. The 24 hour report, nurse's notes and orders are for that. I do not do surveillance." RN #6 was asked if she looks at rashes and whether or not she considered that the rashes that were

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currently observed on the 300 hall may be cross contaminated. RN #6 stated, "I think it was considered." At this time ASM (administrative staff member) #2, the director of nursing, was asked to help clarify the purpose of the infection control log. ASM #2 stated, "The infection control log is our surveillance tool." ASM #2 was asked whether or not the residents currently being treated for scabies should be on the infection control log. ASM #2 stated, "Yes they should." A policy was requested at this time for the infection control program.

A review of the facility document titled, "Introduction Infection Control in Long-Term Care" revealed, in part, the following documentation; "Surveillance: Surveillance refers to a system for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections and detecting unusual pathogens with infection control implications. Data Analysis: 1. An Infection Preventionist, or someone assigned to perform such functions, collects data from the nursing units, categorizes each infection by body site and records the absolute number of infections. Outbreak Management: Infectious outbreaks are infrequent but can be potentially devastating. The two most likely and potentially most dangerous categories of epidemics and outbreaks are respiratory infections and gastrointestinal infections. Other potentially important categories are skin infections....that may spread from multiple sites.

A review of the facility document titled, "Outbreak of Communicable Diseases" revealed, in part, the following documentation; "Policy Statement: Outbreaks of communicable diseases within the

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facility will be promptly identified and appropriately handled. Policy Interpretation and Implementation: 1. An outbreak of most communicable diseases can be defined as one of the following: a. One case of an infection that is highly communicable; c. Occurrence of three (3) or more cases of the same infection over a specified period of time and in a defined area. 8. The Infection Preventionist and Director of Nursing Services will be responsible for: a. Receiving surveillance information and tabulating data. c. Completing the Infection Treatment / Tracking Report form, if required.

A review of the facility document titled, "Surveillance for Infections" revealed, in part the following documentation; "Policy Statement: The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. Policy Interpretation and Implementation: 1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections. 3. Infections that will be included in routine surveillance include those with: a. Evidence of transmissibility in a healthcare environment; d. Pathogens associated with serious outbreaks. (e.g. scabies). Gathering Surveillance Data: 1. The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The Infection Control Committee and / or QAPI (quality assurance

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performance improvement) may be involved in interpretation of the data.

No further information was provided prior to the end of the survey process.

[1] This information was obtained from the following website;
https://medlineplus.gov/scabies.html
Scabies is an itchy skin condition caused by the microscopic mite Sarcoptes scabei. It is common all over the world, and can affect anyone. Scabies spreads quickly in crowded conditions where there is frequent skin-to-skin contact between people. Hospitals, child-care centers, and nursing homes are examples. Scabies can easily infect sex partners and other household members. Sharing clothes, towels, and bedding can sometimes spread scabies. This can happen much more easily when the infested person has crusted scabies. You cannot get scabies from a pet. Pets get a different mite infection called mange.

[2] This information was obtained from the following website;
https://medlineplus.gov/clostridiumdifficileinfections.html
a bacterium that causes diarrhea and more serious intestinal conditions such as colitis. The disease can also be spread in the hospital. The elderly are also at risk. Treatment is with antibiotics.

[3] This information was obtained from the following website;
https://medlineplus.gov/mrsa.html. Infection control is key to stopping MRSA in hospitals

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b. Facility staff failed to sanitize their hands after caring for a resident in isolation, Resident #16. An observation was made on 3/16/17 at 12:24 p.m. of CNA (certified nursing assistant) #4. CNA #4 donned a yellow isolation gown and gloves, she then carried Resident #16's lunch tray into the room and set up the tray for the resident. CNA #4 then went to the sink removed the gloves and gown placed them in a clear plastic trash bag and left the room. CNA #4 did not wash her hands before or after caring for the resident.

An interview was conducted on 3/16/17 at 1:45 p.m. with CNA #1. When asked when staff washes their hands, CNA #1 stated, "Before and after I'm doing a procedure." When asked why staff washed their hands, CNA #1 stated, "To prevent contamination and exchange infection."

An interview was conducted on 3/16/17 at 1:30 p.m. with RN (registered nurse) #3, the evening supervisor. When asked when staff washes their hands, RN #3 stated, "Before and after care. Before doing anything."

An interview was conducted on 3/16/17 at 1:50 p.m. with CNA #4. When asked when staff washes their hands, CNA #4 stated, "When I enter the room and after we complete what I've done." CNA #4 was then informed of the above observation that she did not wash her hands after caring for Resident #16. CNA #4 stated, "I was thinking about that. I did realize I didn't wash my hands."

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On 3/16/17 at 5:15 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the findings.

Review of the facility's policy titled, "HANDWASHING/HAND HYGIENE" documented, "The facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation. 2. All personnel shall follow the handshaking/hand hygiene procedures to help prevent the spread of infections to other personnel, resident, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: m. After removing gloves; n. before and after entering isolation precaution settings...8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections."

No further information was provided prior to exit.

In Fundamentals of Nursing, Lippincott Williams and Wilkins, page 140-143, concerning hand washing and the use of hand sanitizer: "The hands are conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to the patient, or from a staff member to the patient. Hand hygiene is the single most important procedure in preventing infection....typically hands are washed with soap before coming on duty; before and after direct or

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indirect patient contact;...before preparing or administering medications...always wash your hands with soap after removing gloves...when using hand sanitizer, apply a small amount of the alcohol-based hand rub to all surfaces of the hands. Rub hands together until the entire product has dried (usually about 30 seconds)."

c. Facility staff failed to wear an isolation gown appropriately while caring for a resident in isolation, Resident #16.

An observation was made on 3/17/17 at 8:44 a.m. RN #5 was observed putting a yellow isolation gown on. RN #5 had someone tie the string behind her neck and then she took the sleeves of the gown and tied them around her waist leaving her arms unprotected by the isolation gown. RN #5 entered Resident #16's room with medication. RN #5 stood by the resident's bed and fed the medication to the resident. A CNA caring for the resident in the next bed pulled the privacy curtain around brushing the back of RN #5's uniform with it.

An interview was conducted with RN #5 at 8:48 a.m. When asked what the purpose of isolation was, RN #5 stated, "To prevent contamination." When asked if the sleeves of the isolation gown should be on the arms, RN #5 stated they should be. When RN #5 was informed of the above observation, she stated she didn't realize she hadn't put the sleeves on the gown on her arms. She was aware that the curtain brushed against the back of her uniform. RN #5 stated, "It was an oversight."

On 3/17/17 at 8:50 a.m. ASM #2, the director of

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nursing was made aware of the findings.

An interview was conducted with ASM #3, the resident's physician. When asked if the resident's scabies were contagious, ASM #3 stated, "Yes, you can spread it."

No further information was provided prior to exit.

2. The facility staff failed to follow infection control policies and procedures and initiate contact isolation precautions when caring for Resident #17 while being treated for an infectious / contagious condition, scabies.

Resident #17 was admitted to the facility on 1/19/15 with diagnoses that included, but were not limited to, dementia, osteoporosis (a degradation of bone) contractures, agitation, dysphagia (difficulty swallowing) and anxiety.

Resident #17's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/13/16. Resident #17 was unable to respond to the questions on the BIMS (brief interview for mental status) and the staff assessment coded Resident #17 as a three, indicating that Resident #17's decision making is severely impaired.

A review of Resident #17's clinical record revealed the following physician orders;
* "1/2/17 Apply 0.2 % (percent) Westcort ointment (corticosteroid for topical dermatology use.[4]) to rash on chest abdomen and legs BID (two times daily) x 5 (five) days. TO (telephone order) (name of medical doctor)" Signed by medical doctor and dated 1/2/17.

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* "1/30/17 Medrol dose pak (a steroid) dx (diagnosis) skin rash." Signed and dated by medical doctor on 1/30/17.
* "2/23/17 Permethrin (an insecticide [6]) topical apply head to toe one time and wash it off after 12 hours. 2 (two) bottles. Dx. (diagnosis) Scabies." Signed and dated by medical doctor on 2/23/17.
* "3/9/17 T.O. FROM (name of medical doctor) IVERMECTIN (an oral medication used to treat scabies [5]) 3 MG TABLETS. TAKE 4 TABS (tablets) BY MOUTH, REPEAT TREATMENT IN ONE WEEK. V.O. (name of medical doctor) DX. SCABIES." signed and dated by medical doctor on 3/11/17.

Further review of Resident #17's clinical record did not reveal an order for contact isolation.

A review of Resident #17's comprehensive care plan dated 1/19/15 revealed, in part, the following handwritten entries; "1/30/17 Rash all over body. 1/23/17 Rash over body. 3/10/17. Scabies / Rash. Approaches: 2/23/17 Permethrin cream. 3/10/17 Tx (treatment) per order. prednisone. Be aware of itching." There were no entries in the comprehensive care plan related to contact isolation.

A review of Resident #17's clinical record revealed week skin check forms. An entry on March 10 2017 revealed, by diagram, that Resident #17 had a rash on her chest, upper and lower back, bilateral outer thighs, abdomen and bilateral upper thighs.

A review of Resident #17's nursing notes did not reveal any information related to a diagnosis of scabies and/or the need for contact isolation.

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On 3/15/17 at 5:00 p.m. Resident #17 was observed in her room. The doorway to the room did not have any indication that Resident #17 was on contact isolation. There were no gowns or gloves observed at the point of entry into Resident #17's room. Resident #17 was lying in her bed and was observed vigorously scratching around her neck and face. This surveyor was observed by a nurse in the hallway entering Resident #17's room and no attempt was made by the nurse to stop this surveyor from entering without an isolation gown or gloves.

On 3/15/17 at 5:08 p.m. OSM (other staff member) #6 (a nurse aide student) was observed entering Resident #17's room without any isolation gown or gloves. OSM #6 was observed standing against Resident #16's bed (Resident #17's roommate); his clothes were in full contact with the bed. OSM #6 did not wash his hands when he exited the room. At this time an interview was conducted with OSM #6. OSM #6 was asked if anyone on the hallway was on contact isolation. OSM #6 stated that there was only one resident on contact isolation and he pointed to the room opposite to Resident #17's room. OSM #6 was then asked if anyone else was on contact isolation. OSM #6 stated "no."

On 3/15/17 at 5:20 p.m. CNA (certified nursing assistant) #8 was observed providing ADL (activities of daily living) care to Resident #17, this surveyor maintained a position against the wall with full visibility of CNA #8's activity. CNA #8 was observed not wearing a gown and gloves. CNA #6 was observed pulling the privacy curtain around the bed without gloves and also pulled the window curtains closed. CNA #8 put on gloves

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and then proceeded to roll Resident #17 onto her right side, he removed Resident #17's diaper and wiped the perianal area with a towel and blotted with tissues. The sheets beneath Resident #17 were observed soaked through to the mattress with urine. CNA #8 disposed of the tissues and wet diaper in the trash can beneath the sink. CNA #8 then placed the soiled linens into a regular, clear trash bag that he retrieved from a roll above the paper towel dispenser. Resident #17 was observed to have several, round shaped lesions on her right leg. Once CNA #8 had cleaned Resident #17 and placed a dry diaper on her, he placed clean linen on the bed. Once finished CNA #8 removed his gloves, opened the curtains and left the room. He did not wash his hands when leaving the room.

On 3/16/17 at 7:55 a.m. Resident #17's room was observed. There was no signage outside the room to indicate that there was a concern for contact isolation. There were no gowns or gloves observed at the entry way of the room.

On 3/16/17 at 8:25 a.m. a nurse's aide was observed retrieving an isolation gown from a storage closet by the nurses station, which she put on and then placed gloves on. The nurse's aide then entered the doorway of the room and a second aide passed the tray to the nurse's aide in the room.

On 3/16/17 at 1:20 p.m. an interview was conducted with OSM (other staff member) #8, the pharmacist. OSM #8 was asked to explain why ivermectin would be prescribed. OSM #8 stated it was used to treat scabies. OSM #8 was asked how ivermectin would be prescribed/ dosed. OSM #8 stated that generally it would be given

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once and then repeated one week later. OSM #8 further stated that usually one dose would suffice but that if a person continued to be symptomatic (itching and continued rash) precautions should be carried over and a second dose would be given "just to be safe." OSM #8 further stated that the manufacturers' recommendations stated that if the person was infected with "Norwegian" scabies then dosing would be recommended for days one, two, eight, nine and fifteen with the option of additional dosing on days 22 and 29.

On 3/16/17 at approximately 1:50 p.m. an interview was conducted with OSM #7, the Loudoun County Health Department nurse. OSM #7 was asked to describe the recommended treatment for suspected scabies. OSM #7 stated, "The first line of treatment is Permethrin cream, the instruction is to cover the body head to toe and leave on for 12 hours, then wash it off. All the linens must be changed and cleaned, the clothing washed and bagged and contact isolation is recommended for staff members and non-exposed individuals until treatment has completed." OSM #7 was asked where these recommendations were from, OSM #7 stated, "The CDC (centers of disease control). OSM #7 was asked when treatment was considered complete. OSM #7 stated, "Even after treatment a person may still be symptomatic, may have a rash and itching. If a person persists with symptoms then the treatment should be retreated. As long as a person persists with itching and a rash, contact precautions should be continued. OSM #7 was asked how to prevent the spread of scabies. OSM #7 stated, "You have to avoid direct contact with those contaminated, as well as bedding and clothing, or anything else that has been in contact with the infected person."

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OSM #7 was asked how staff could determine if the treatment was successful. OSM #7 stated, "They could look at the skin and determine if there are any new burrows from the mites."

On 3/16/17 at 5:05 p.m. an end of day meeting was held with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant. The administrative staff was asked what reference guide they used for the treatment of scabies and the prevention of a scabies outbreak in the facility. ASM #2 stated that the policies were based on the CDC recommendations. ASM #2 was asked why the residents diagnosed with scabies had not been placed on contact isolation as recommended by the local health department and the CDC. ASM #2 stated that the rash was a-typical (absent of typical symptoms) and therefore they continued to be suspicious of scabies but not convinced that the rashes presented were actually scabies. ASM #2 was shown evidence that the first diagnosis for scabies actually occurred on 2/23/17 for Resident #17. ASM #2 was asked if Resident #17 was placed on contact isolation at that time. ASM #2 was not able to state that contact isolation had been put in place. ASM #2 stated, "I did not put a cart (isolation) outside of the door. The staff had a choice. We did not have a conclusive diagnosis." ASM #2 was asked if contact isolation was put into place on 2/23/17, ASM #2 stated it was not. A copy of the facility policy for identification, prevention and treatment of scabies was requested at this time.

The facility policy "Scabies" revealed, in part, the following documentation; Purpose: The purpose of this procedure is to treat residents infected with

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and sensitized to Sarcoptesscabiei and to prevent the spread of scabies to other residents and staff. Preparation: 2. Review the resident's care plan to assess for any special needs of the resident. General Guidelines: 3. Scabies is spread by skin to skin contact with the infected area, or through contact with bedding, clothing, privacy curtains and some furniture. 5. Affected residents should remain on Contact Precautions until twenty-four (24) hours after treatment. 9. Individuals who come into contact with the infected resident or with potentially contaminated bedding or clothing should wear a gown and gloves or other protective clothing as established by the facility's infection and exposure control programs.

On 3/17/17 at 9:45 a.m. an interview was conducted with ASM #3, the medical doctor. ASM #3 was asked how he would treat a resident with scabies. ASM #3 stated, "Since we do not have the ability to perform a scrape test (a method by which the infected area of skin is scraped and the mites are identified microscopically), observation/clinical diagnosis determines whether or not the person is infected with scabies. I look for burrows but it is sometimes hard to diagnose." ASM #3 was asked how he would treat scabies. ASM #3 stated, "First I would treat with a lotion, it is applied from the neck down and washed off after 12 hours. In three to four days I would do a second application of lotion. After two applications, if there is still a rash, I would do a diagnostic test for a positive diagnosis." When asked if these steps had been taken with Resident #17, ASM #3 could only speak to the one application of lotion and one dose of oral medication being administered. There had not been any attempt at a diagnostic test being

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HERITAGE HALL NRSG AND REHAB	122 MORVEN PARK ROAD NW LEESBURG, VA 20176

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performed. ASM #3 was asked how staff prevented spreading scabies. ASM #3 stated, "The staff has to be careful and wear gloves and yellow gowns. Keep wash cloths and linen separate from other residents. You can spread scabies if you do not wear the gown and gloves. Scabies is a contagious disease." ASM #3 was asked when treatment is considered over. ASM #3 stated when the resident is improved and all treatments have been completed.

No further information was provided prior to the end of the survey process.

[4] This information was obtained from the following website;
http://www.rxlist.com/westcort-ointment-drug.htm
The corticosteroids constitute a class of primarily synthetic steroids used topically as anti-inflammatory and antipruritic agents

[5] This information was obtained from the following website:
https://medlineplus.gov/druginfo/meds/a607069.html
Ivermectin is also sometimes used to treat certain other roundworm infections, head or pubic lice infestation, and scabies (itchy skin condition caused by infestation with small mites that live under the skin).

[6] This information was obtained from the following website;
https://patient.info/medicine/permethrin-cream-lyclear
Permethrin contains an insecticide. It kills insects (parasites) that live on humans, such as the scabies mite.

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3a. The facility staff failed to follow infection control policies and procedures and initiate contact isolation precautions when caring for Resident #16 while being treated for an infectious / contagious condition, scabies.

Resident #16 was admitted to the facility on 1/9/15 with a readmission date of 7/28/16 with diagnoses that included, but were not limited to, high blood pressure, atrial fibrillation (an irregular heartbeat) and depression.

Resident #16's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/13/17. Resident #16 was coded on her BIMS (brief interview for mental status) as scoring 15 out of 15, indicating that Resident #16 did not have any cognitive deficits.

A review of Resident #16's clinical record revealed, in part, the following physician orders;
- 2/23/17 Permethrin topical apply head to toe one time and wash it off after 12 hours. 2 (two) bottles. Dx. (diagnosis) Scabies." Signed and dated by the medical doctor on 2/23/17.
- "3/9/17 T.O. (telephone order) from (name of medical doctor) INVERMECTIN (sic) 3 MG (milligrams) TABLETS TAKE FOUR TABLETS BY MOUTH REPEAT IN ONE WEEK. DX. (diagnosis) SCABIES." Signed and dated by medical doctor on 3/17/17.

A review of Resident #16's nursing notes revealed, in part, the following documentation; "3/11/2017 6:22 p.m. Resident with orders for multiple anti-infection medication including rocephin (an antibiotic), levaquin (an antibiotic)

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and ivermectin (used to treat scabies). Resident refused to take medications as prescribed, stating she prefers "Vitamin C powder" and further discussion with MD (medical doctor). Resident informed of benefit of current medication regimen. Resident still refused the above referenced medications. MD and POA (power of attorney) notified. POA expressed knowledge of resident's history to refuse treatment." Signed and dated by RN (registered nurse) #6, the infection control nurse.

Further review of Resident #16's nursing notes did not reveal any documentation regarding contact isolation for a diagnosis of scabies or that the medication, Ivermectin, used to treat scabies had been administered.

A review of Resident #16's comprehensive care plan dated 7/28/16 revealed, in part, the following documentation; "Problem/Need: 3/10/17 scabies/rash. Scratches neck, shoulders, chest, redness, swelling. Approaches: 3/10/17 Tx (treatment) per order (Ivermectin)."

On 3/15/17 at 5:08 p.m. OSM (other staff member) #6 (a nurse aide student) was observed entering Resident #16's room without any isolation gown or gloves. OSM #6 was observed standing against Resident #16's bed; his clothes were in full contact with the bed. OSM #6 did not wash his hands when he exited the room. OSM #6 was interviewed at this time and asked if anyone on the hallway was on contact isolation. OSM #6 stated that there was only one resident on contact isolation and he pointed to the room opposite to Resident #16's room. OSM #6 was asked if anyone else was on contact isolation. OSM #6 stated "no."

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On 3/16/17 at 7:55 a.m. Resident #16's room was observed. There was no signage outside the room to indicate that there was a concern for contact isolation. There were no gowns or gloves observed at the entry way of the room.

On 3/16/17 at 1:20 p.m. an interview was conducted with OSM (other staff member) #8, the pharmacist. OSM #8 was asked to explain why ivermectin would be prescribed. OSM #8 stated it was used to treat scabies. OSM #8 was asked how ivermectin would be prescribed/ dosed. OSM #8 stated that generally it would be given once and then repeated one week later. OSM #8 further stated that usually one dose would suffice but that if a person continued to be symptomatic (itching and continued rash) precautions should be carried over and a second dose would be given "just to be safe." OSM #8 further stated that the manufacturers' recommendations stated that if the person was infected with "Norwegian" scabies then dosing would be recommended for days one, two, eight, nine and fifteen with the option of additional dosing on days 22 and 29.

On 3/16/17 at approximately 1:50 p.m. an interview was conducted with OSM #7, the Loudoun County Health Department nurse. OSM #7 was asked to describe the recommended treatment for suspected scabies. OSM #7 stated, "The first line of treatment is Permethrin cream, the instruction is to cover the body head to toe and leave on for 12 hours, then wash it off. All the linens must be changed and cleaned, the clothing washed and bagged and contact isolation is recommended for staff members and non-exposed individuals until treatment has completed." OSM #7 was asked where the

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recommendations were from, OSM #7 stated, "The CDC (centers of disease control). OSM #7 was asked when treatment was considered complete. OSM #7 stated, "Even after treatment a person may still be symptomatic, may have a rash and itching. If a person persists with symptoms then the treatment should be retreated. As long as a person persists with itching and a rash, contact precautions should be continued. OSM #7 was asked how to preventthe spread of scabies. OSM #7 stated, "You have to avoid direct contact with those contaminated, as well as bedding and clothing, or anything else that has been in contact with the infected person." OSM #7 was asked how staff could determine if the treatment was successful. OSM #7 stated, "They could look at the skin and determine if there are any new burrows from the mites."

On 3/16/17 at 5:05 p.m. an end of day meeting was held with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant. The administrative staff was asked what reference guide they used for the treatment of scabies and the prevention of a scabies outbreak in the facility. ASM #2 stated that the policies were based on the CDC recommendations. ASM #2 was asked why the residents diagnosed with scabies had not been placed on contact isolation as recommended by the local health department and the CDC. ASM #2 stated that the rash was a-typical (absent of typical symptoms) and therefore they continued to be suspicious of scabies but not convinced that the rashes presented were actually scabies. ASM #2 was shown evidence that the first diagnosis for scabies actually occurred on 2/23/17 for Resident #16. ASM #2 was asked if

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Resident #16 was placed on contact isolation at that time. ASM #2 was not able to state that contact isolation had been put in place. ASM #2 stated, "I did not put a cart (isolation) outside of the door. The staff had a choice. We did not have a conclusive diagnosis." ASM #2 was asked if contact isolation was put into place on 2/23/17, ASM #2 stated it was not. A copy of the facility policy for identification, prevention and treatment of scabies was requested at this time.

The facility policy "Scabies" revealed, in part, the following documentation; Purpose: The purpose of this procedure is to treat residents infected with and sensitized to Sarcoptesscabiei and to prevent the spread of scabies to other residents and staff. Preparation: 2. Review the resident's care plan to assess for any special needs of the resident. General Guidelines: 3. Scabies is spread by skin to skin contact with the infected area, or through contact with bedding, clothing, privacy curtains and some furniture. 5. Affected residents should remain on Contact Precautions until twenty-four (24) hours after treatment. 9. Individuals who come into contact with the infected resident or with potentially contaminated bedding or clothing should wear a gown and gloves or other protective clothing as established by the facility's infection and exposure control programs.

On 3/17/17 at 9:45 a.m. an interview was conducted with ASM #3, the medical doctor. ASM #3 was asked how he would treat a resident with scabies. ASM #3 stated, "Since we do not have the ability to perform a scrape test (a method by which the infected area of skin is scraped and the mites are identified microscopically), observation/clinical diagnosis determines whether or not the person is infected

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F 441	Continued From page 65 with scabies. I look for burrows but it is sometimes hard to diagnose." ASM #3 was asked how he would treat scabies. ASM #3 stated, "First I would treat with a lotion, it is applied from the neck down and washed off after 12 hours. In three to four days I would do a second application of lotion. After two applications, if there is still a rash, I would do a diagnostic test for a positive diagnosis." When asked if these steps had been taken with Resident #16, ASM #3 could only speak to the one application of lotion and one dose of oral medication being administered; ASM #3 was unable to recall Resident #16 refusing the one dose of ivermectin as documented in the nursing notes. There had not been any attempt at a diagnostic test being performed. ASM #3 was asked how staff prevented spreading scabies. ASM #3 stated, "The staff has to be careful and wear gloves and yellow gowns. Keep wash cloths and linen separate from other residents. You can spread scabies if you do not wear the gown and gloves. Scabies is a contagious disease." ASM #3 was asked when treatment is considered over. ASM #3 stated when the resident is improved and all treatments have been completed. No further information was provided prior to the end of the survey process.	F 441		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 514	F514 Corrective Action(s): Resident #9's attending physician has been notified that the facility staff failed to document the non-pharmacological interventions attempted prior to the administration of a psychoactive medication. A facility incident and accident form has been completed for this incident.	

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(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
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 one of 26 residents in the survey sample, Resident #9.

The facility staff failed to document non-pharmacological interventions they attempted prior to the administration of psychoactive medication to Resident #9.

Identification of Deficient Practices & Corrective Action(s):
All other residents may have potentially been affected. A 100% review of all residents receiving routine or PRN psychoactive medication orders and MAR's, will be conducted by the DON and/or Unit Manager to identify residents at risk for inappropriate documentation of non-pharmacological interventions. All negative findings will be clarified and/or correct at time of discovery. A facility Incident & Accident form will be completed for each negative finding.

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant on the clinical documentation standards per facility policy and procedure. This inservice will include the standards for proper documentation for interventions both pharmacological and non-pharmacological implemented when administering psychoactive medications.

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The findings include:

Resident #9 was admitted to the facility on 11/26/16 with diagnoses including, but not limited to: heart disease, Alzheimer's disease, anxiety, and high blood pressure. On the most recent MDS (minimum data set), a 14-day assessment with an assessment reference date of 2/11/17, Resident #9 was coded as having both short term and long term memory loss, and as being moderately impaired for making daily decisions. She was coded as having received medication to treat anxiety on all seven days of the look back period.

A review of Resident #9's clinical record revealed the following physician's order, written 12/2/16 and most recently signed by the physician on 3/13/17: "Xanax (Alprazolam) (used to treat anxiety disorders and panic disorder [1]) 0.25 mg (milligrams) tablet give one tab (tablet) po (by mouth) BID (twice a day) prn (as needed)."

A review of the MARs (medication administration records) for Resident #9 revealed that Xanax was administered according to the above referenced order on 1/3/17 at 2:44 a.m., 1/4/17 at 12:41 a.m., 1/7/17 at 12:04 a.m., 1/14/17 at 2:58 a.m., 2/14/17 at 2:43 a.m. and 2/19/17 at 3:14 a.m. by LPN (licensed practical nurse) #9. A review of the nurses' notes revealed no accompanying documentation on these dates and times, including no description of non-pharmacological interventions attempted prior to the administration of the prn Xanax.

On 3/16/17 at 4:05 p.m., LPN #9 was interviewed. She stated that she would give a prn medication

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or designee will audit medical 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: 4/28/2017

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like Xanax to a resident who is showing increased signs and symptoms of anxiety. LPN #9 stated: "I always try other things beforehand - either a different activity, offer a snack, see if they are in pain. I try other options before giving them medicine." When asked where she documents these interventions, LPN #9 stated: "In the nurses' notes." When asked about the dates and times referenced above, and informed that there were no nurses' notes for these dates and times, LPN #9 stated: "I must have just forgotten to document. I always try other things before I give the medication."

On 3/16/17 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional consultant, were informed of these concerns.

A review of the facility policy titled "Charting and Documentation" revealed, in part, the following: "All observations, medications administered, services performed, etc., must be documented in the resident's clinical records."

No further information was provided prior to exit.

(1) "Alprazolam is used to treat anxiety disorders and panic disorder (sudden, unexpected attacks of extreme fear and worry about these attacks). Alprazolam is in a class of medications called benzodiazepines. It works by decreasing abnormal excitement in the brain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a684001.html.

According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins,

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Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team."