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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495371	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL-RICH CREEK	120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147

(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 8/9/16 through 8/11/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 106 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents 1 through 19) and 4 closed record reviews (Residents 20 through 23).	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155	F155 **Corrective Action(s):** Resident #22 has had their DDNR form and physician orders reviewed by the attending physician and they have been updated and correctly completed to reflect resident #22's code status. An Incident and Accident form was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have been potentially affected. The Admission Director and/or Social Services Director will review all resident's medical records to ensure the DDNR is accurately filled out. Any negative findings with result in the Admission Director and/or Social Services Director to contact all responsible parties to verify each resident's code status and advance directives to insure that the proper status has been explained and that written notification has been placed in the medical record.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: _____ TITLE: Administrator (X6) DATE: 8/31/16

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

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F 155	Continued From page 1	F 155		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure the DDNR (Durable Do Not Resuscitate) was complete and accurate for 1 of 23 residents (Resident #22).
The findings included:
The facility staff failed to ensure Resident #22's DDNR (Durable Do Not Resuscitate) forms were complete and accurate.
The surveyor reviewed Resident #22's clinical record on 8/11/16. Resident #22 was admitted to the facility 6/22/16 with diagnoses that included but not limited to hepatomegaly, diverticulosis, gallstones, hypothyroidism without goiter, hypercholesterolemia, hypertension, Type 2 diabetes mellitus, gastroesophageal reflux disease, Alzheimer's disease, dementia with behavioral disturbances, cognitive communication deficit, and dysphagia.
Resident #22's 5 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/29/16 assessed the cognitive status as 07 out of 15 in Section C Summary Score.
The clinical record contained two (2) Virginia Department of Health Durable Do Not Resuscitate (DDNR) orders both dated 6/22/16.
The DDNR forms included in the clinical record read in part:

I further certify (must check 1 or 2):
1. The patient is CAPABLE of making an informed decision...
2. The patient is INCAPABLE of making an informed decision...

If you checked 2 above, check A, B, or C below:
A. While capable of making an informed

Systemic Change(s):
The Facility policy and procedure was reviewed and no changes are warranted at this time. The Admissions Director has been inserviced on the proper completion of a DDNR and Advance Directives when required. The Admission Director will discuss with each future Admission their advance directors and resuscitation status upon admission to the facility. Any/all concerns expressed will be reported to the Administrator. The Administrator & Director of Nursing will speak to those concerned or with questions about each area & follow through on all concerns to ensure proper resuscitation status is reflected in the medical record.

Monitoring:
The Admission Director and Social Services Director are responsible for maintaining compliance. The Admission Director and/or Social Service Director will audit all Residents medical records monthly to monitor compliance for having a current resuscitation order and/or advance directive Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation.
Completion Date: 9/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 155 Continued From page 2

decision, the patient has executed a written advanced directive...

B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf "...

C. The patient has not executed a written advanced directive...

There were no checks in any of the boxes on either of the DDNR forms. The section at the bottom of the DDNR form had been signed by the physician and the person authorized to consent on the patient's behalf. The form was dated 6/22/16.

A review of the admission physician orders dated 6/22/16 identified Resident #22 as "DNR-Do Nol Resuscitate".

The surveyor interviewed the unit manager licensed practical nurse #7 on 8/11/16 at 10:00 a.m. The surveyor showed the unit manager the current DDNR forms in the clinical record and questioned who was responsible for their completion. She stated she thought admissions were responsible for the completion of the DDNRs.

The surveyor informed the administrator, the director of nursing the assistant director of nursing, and the regional registered nurse of the above finding on 8/11/16 at 12:15 p.m.

No further information was provided prior to the exit conference on 8/11/16.

F 155

F 226 SS=D 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit

F 226

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F 226	Continued From page 3 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, employee record review and the Code of Virginia, the facility staff failed to implement abuse prevention protocol for the screening of new employees for 1 of 5 new employees, new employee #5. The findings included: The facility staff failed to obtain pre-employment reference checks per facility policy and failed to obtain a criminal record check through the Virginia State Police Central Criminal Records Exchange for employee #5. New employee #5's personnel file was reviewed 8/11/16. Employee #5's application was dated 12/27/15 and hired as a COTA (certified occupational therapy assistant) through the facility's contracting rehabilitation services. Upon review of the employee file, the surveyor was unable to locate reference checks and the criminal record check obtained through the Virginia State Police Central Criminal Records Exchange. The surveyor interviewed the regional representative for the contracted rehabilitation professionals (other #3) on 8/11/16 at 10:50. The surveyor requested any information that could provide details of employee #5's references prior	F 226	**F226** **Corrective Action(s):** Contract employee #5 has had reference checks completed and a criminal background check completed through the Virginia State Police per the policy and I s on-sight at the facility. A facility Incident and Accident for has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other employees may have been potentially affected. The Human Resources department will audit 100% of all active employee records to include contract employees to identify employees at risk. Any/all negative findings will be corrected at the time of discovery. A Facility Incident and Accident Report will be completed for any/all negative findings. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. Administrative Staff, Department Managers and the HR department will be inserviced and issued a copy of the policy & procedure regarding abuse prevention and pre-employment procedures by the Administrator. Administrative Staff and Department Heads extending employment without meeting the requirements of the established facility policy & ptocedure will receive disciplinary action. Perspective employees will not he allnwed to work until all required documentation has been obtained.	

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F 226	Continued From page 4 to hiring as well as the criminal record check through the Virginia State Police. Other #3 stated the reference checks, he thought, were only written if there was a concern about the employee and stated he thought there was a disclaimer on the application. The surveyor was unable to locate a disclaimer for reference checks on the application. Employee #5 had listed three references on the application. Other #3 provided the surveyor with a "Criminal Justice Information Services (CJIS) Division of the Federal Bureau of Investigation (FBI)" fingerprint submission for employee #5 that was dated 4/7/16. It read "A search of the fingerprints provided by this individual has revealed prior arrest data at the FBI. This does not preclude further criminal history at the state or local level." The surveyor reviewed the facility's policy for abuse/screening that was requested at the entrance conference on 8/9/16. The policy entitled "Guidelines for the Prevention of Abuse" read in part "Policy: 4. Careful screening of all employees, physicians, and contracted professionals. All information provided by the applicant is verified and at least two references are contacted with documentation maintained in the personnel file." Excerpt from the Code of Virginia updated September 2014-"Criminal Records-Employment Barrier Crimes-State law (§32.1-126.01 and 32.1-162.9:1 of the Code of Virginia) requires that each...nursing home...obtain a criminal record background check on new hires within 30 days of employment. The law requires that these background checks be obtained using the Central Criminal Records Exchange from the Virginia	F 226	**Monitoring:** The Human Resources Manager is responsible for maintaining compliance. The Human Resources Director and/or designee will conduct monthly audits of all new hire employee files for each month to maintain compliance. The administrator will review all audits and report aggregate findings to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date:** 9/21/16	

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F 226	Continued From page 5 State Police." The failure of the facility to follow their policy for abuse prevention was brought to the attention of the administrative staff during a meeting on 8/11/16 at 12:15 p.m. No further information was provided prior to exit on 8/11/16.	F 226		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272	**F272** **Corrective Action(s):** Resident #10 identified in the survey sample has had their Care Area Assessment Summary revised to reflect the location of the of documentation describing the resident's clinical for psychotropic medication use and other factors that may impact care planning decisions. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially affected. A 100% review of all Care Area Assessment Summary's will be completed by the RCC and/or designee to identify residents affected. All residents affected will have their Care Area Assessment Summary's corrected at time of discover. **Systemic Change(s):** The facility policy and procedure was reviewed and no changes are warranted at this time. The regional nurse consultant will inservice the Resident Care Coordinator's and the interdisciplinary Care Plan Team on accurately completely the Care Area Assessment Summary. This will include accurate documentation indicating the date and location of documentation describing each resident's clinical status and other factors that impact care planning.	

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F 272	Continued From page 6 Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate Care Area Assessment (CAA) for 1 of 23 Residents in the sample survey, Resident #10.
The Findings Included:
Resident #10 was a 76 year old male who was admitted on 2/8/15. Admitting diagnoses included, but were not limited to: dementia with behaviors, diabetes mellitus, hypertension, anemia and chronic ischemic heart disease.
The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 7/20/16. The facility staff coded that Resident #10 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #10 required limited assistance (2/2) with Activities of Daily Living (ADL's). In Section N. Medications received 7 days of a psychotropic medication.
On August 9, 2016 at 3:35 p.m. the surveyor reviewed Resident #10's clinical record. Review of the clinical record produced signed physician orders dated 7/2/16. Signed physician orders

Monitoring:
The RCC is responsible for maintaining compliance. The RCC will complete MDS audit tool weekly coinciding with the MDS calendar to monitor for compliance. Any/all negative findings will be reported to the RCC and the DON at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice.
Completion Date: 9/21/16

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included, but were not limited to: "Seroquel 50 mg tablet. Take 1 tab po BID (by mouth twice daily). DX (diagnoses) Dementia with behaviors. Generic: Quetiapine Fumarate." (sic) The order originated on 3/23/15.
Continued review of the clinical record produced an Annual MDS assessment with the ARD of 2/3/16. The facility staff coded that Resident #10 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #10 required limited (2/2) to extensive assistance (3/2) with ADL's. In Section N. Medications the facility staff coded that Resident #10 received 7 days of a psychotropic medication. In Section V. Care Area Assessment (CAA) Resident #10 "triggered" for psychotropic drug use. The facility staff failed to document in the "Location and Date of CAA documentation" where the supporting documentation could be located in the clinical record.
On August 9, 2016 at 4:40 p.m. the surveyor notified the MDS Nurse, who was a Licensed Practical Nurse (LPN #2) that Resident #10's CAA Summary was incomplete/inaccurate. The surveyor reviewed the Annual MDS with the ARD of 2/3/16 with the MDS Nurse (LPN #2). The surveyor pointed out that Resident #10 "triggered" for Psychotropic Drug Use. The surveyor also pointed out that the location of the supporting documentation was not documented in the CAA Summary Location and Date of Supporting Documentation. The MDS Nurse (LPN #2) stated, "You are right, it's not there."
On August 10, 2016 at 3:55 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure a

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F 272	Continued From page 8 complete and accurate CAA Summary for Resident #10. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate CAA Summary for Resident #10.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	**F278** **Corrective Action(s):** Resident #16 has had their most recent quarterly MDS modified by the MDS coordinator to accurately code section H for the use of a Foley catheter on the MDS. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all current resident assessments will be completed by the MDS Coordinator and/or designee to ensure that MDS section H is assessed and coded correctly. All negative findings will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS. **Systemic Change(s):** The Resident Interdisciplinary Care Team has been inserviced by the MDS coordinator on the proper assessment and coding of all areas of the MDS to include section K of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and the IDT Team to ensure the accuracy and integrity of resident data.	

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F 278	Continued From page 9	F 278		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for 1 of 23 in the sample survey, Resident #16.
The Findings Included:
Resident #16 was a 93 year old male who was admitted on 7/27/16. Admitting diagnoses included, but were not limited to: rib fracture, pulmonary effusion, pneumothorax, hypertension, hypothyroidism, dementia and benign prostatic hyperplasia (BPH).
The most current Minimum Data Set (MDS) located in the clinical record was an Admission and 5 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 8/3/16. The facility staff coded that Resident #16 had a Cognitive Summary Score of 8. The facility staff also coded that Resident #16 required extensive assistance (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's). In Section H. Bladder and Bowel the facility staff did not code that Resident #16 had an indwelling Foley catheter in the look back period of 7 days.
On August 11, 2016 at 8:30 a.m. the surveyor reviewed Resident #16's clinical record. Review of the clinical record produced a hospital Discharge Summary dated 7/27/16 that documented that Resident #16 had: "10. BPH (benign prostatic hypertrophy) -No urinary symptoms -continue home meds (medications)-keep foley in due to trouble standing to urinate." (sic)
Further review of the clinical record produced a Physician Progress note dated 7/27/16. The Physician Progress Note documented: "Benign Prostatic Hypertrophy without obstruction Will

Monitoring:
The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date: 9/21/16

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clamp catheter and wean and D/c (discontinue) when we can." (sic)
Continued review of the clinical record produced nursing notes: "7/28/16 12:10 AM ...16 f (French) catheter in place and draining dark yellow urine ... " (sic) .
The Foley catheter was discontinued on 7/29/16 at 2 p.m.
The surveyor noted that the Foley catheter was not coded on the Admission and 5 Day Medicare MDS with the ARD of 8/3/16.
On August 11, 2016 at 9 a.m. the surveyor at 9 a.m. the surveyor notified the MDS Nurse, who was a Licensed Practical Nurse (LPN #8), that Resident #16's Admission and 5 Day Medicare MDS was inaccurate. The surveyor notified the MDS Nurse (LPN #8) that Resident #16 had an indwelling Foley catheter while in the hospital. The surveyor notified the MDS Nurse (LPN#8) that when Resident #16 was admitted into the facility the indwelling Foley catheter was still in place. The surveyor reviewed the clinical record with the MDS Nurse (LPN #8). The surveyor pointed out the hospital discharge summary, physician progress note and the nursing notes. The surveyor then reviewed the Admission and 5 Day Medicare MDS with the ARD of 8/3/16 with the MDS Nurse (LPN #8). The surveyor pointed out that the Foley catheter was not coded in Section H. The MDS Nurse (LPN #8) stated, "She did not code it."
On August 11, 2016 at 11:15 a.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff did not code Resident #16 as having a Foley catheter on the Admission and 5 Day Medicare MDS assessment

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	495371	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL-RICH CREEK	120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147

(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 278	Continued From page 11 with the ARD of 8/3/16. On additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #16.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to develop a Comprehensive Care Plan (CCP) for 1 of 23 Residents in the sample survey, Resident #10. The Findings Included:	F 279	**F 279** **Corrective Action(s):** Resident #10's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's Urinary Incontinence status that was triggered on the Care Area Assessment Summary (CAA's). A Facility Incident & Accident Form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all comprehensive care plans will be conducted by the RCC and/or designee to identify residents with inaccurate or incomplete care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. A Facility Incident & Accident Form will be completed for each incident identified.	

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Resident #10 was a 76 year old male who was admitted on 2/8/15. Admitting diagnoses included, but were not limited to: dementia with behaviors, diabetes mellitus, hypertension, anemia and chronic ischemic heart disease. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 7/20/16. The facility staff coded that Resident #10 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #10 required limited assistance (2/2) with Activities of Daily Living (ADL's). In Section H. Bladder and Bowel the facility staff coded that Resident #10 was "Occasionally Incontinent" of bladder and bowel. On August 9, 2016 at 3:35 p.m. the surveyor reviewed Resident #10's clinical record. Review of the clinical record produced an Annual MDS assessment with the ARD of 2/3/16. The facility staff coded that Resident #10 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #10 required limited (2/2) to extensive assistance (3/2) with ADL's. In Section H. Bladder and Bowel the facility staff coded that Resident #10 was continent of bladder and bowel. However, in Section V. Care Area Assessment Summary (CAA's) Resident #10 "triggered" for Urinary Incontinence/Rehabilitation Potential. The facility staff documented to see the supporting documentation in the "adl sheet 2/3/16." (sic) The facility staff documented that a care plan would be developed to address Resident #10's Urinary Incontinence/Rehabilitation Potential. Continued review of the clinical record produced the Comprehensive Care Plan (CCP) dated 2/4/16. Review of the CCP failed to produce a care plan that addressed Resident #10's Urinary

Systemic Changes:
The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC will be inscrviced by the DON and/or Regional Nurse consultant on the development and implementation process of individualized care plans.

Monitoring:
The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON and/or RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.

Completion Date: 9/21/16

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F 279	Continued From page 13 Incontinence/Rehabilitation Potential. On August 9, 2016 at 4:40 p.m. the surveyor notified the MDS Nurse, who was a Licensed Practical Nurse (LPN #2) that Resident #10's did not have a CCP. The surveyor reviewed the Annual MDS with the ARD of 2/3/16 with the MDS Nurse (LPN #2). The surveyor pointed out Section V. CAA's. The surveyor pointed out that Resident #10 "triggered" for Urinary Incontinence/Rehabilitation Potential and that the facility had documented that a care plan would be developed for Resident #10's Urinary Incontinence/Rehabilitation Potential. The surveyor notified the MDS Nurse (LPN #2) that a care plan could not be located to address Resident #10's Urinary Incontinence/Rehabilitation Potential. The MDS Nurse (LPN #2) reviewed the CCP and could not locate a care plan that addressed Resident #10's triggered Urinary Incontinence/Rehabilitation Potential. On August 10, 2016 at 3:55 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to develop a CCP, to included Urinary Incontinence/Rehabilitation Potential, for Resident #10. No additional information was provided prior to exiting the facility as to why the facility staff failed to develop a CCP for Resident #10.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		

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F 280	Continued From page 14	F 280		

incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the current comprehensive care plan for 1 of 23 residents (Resident #6). The use of Bilateral ulnar drift splints for Resident #6 had not been placed on the current comprehensive care plan.

The findings included:

The facility staff failed to revise Resident #6's current comprehensive care plan to incorporate the use of bilateral ulnar drift splints at bedtime.

Resident #6 was admitted to the facility 5/6/14 and readmitted 12/27/15 with diagnoses that included but not limited to rheumatoid arthritis,

F-280
Corrective Action(s):
Resident 6's comprehensive care plan has been reviewed and revised to reflect the resident's use of bilateral ulnar drift splints at bedtime. A Facility Incident & Accident Form was completed for this incident.

Identification of Deficient Practices & Corrective Action(s):
All other residents with physician ordered splinting equipment may have potentially been affected. A 100% review of all comprehensive care plans for residents with splinting devices will be conducted by the RCC's and/or designee to identify residents at risk. Residents identified at risk will have their comprehensive care plans updated and revised to reflect their currents needs and interventions to meet their resident specific care needs to prevent or minimize any further weight loss. A facility Incident & Accident Form will be completed for each incident identified.

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chronic obstructive pulmonary disease, hypertension, atherosclerotic heart disease, hypokalemia, gastroesophageal reflux disease, hypercholesterolemia, depressive disorder, nutritional anemia, and anxiety.

Resident #6's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/29/16 assessed the resident with a brief interview for mental status as 09 out of 15.

The most recent signed physician orders were July 2016. The orders included for staff to apply (B) ulnar drift splint daily and remove (B) ulnar drift splint daily.

The surveyor observed Resident #6 numerous times during the survey without the splint-8/10/16 at 7:35 a.m. while in bed, 8/10/16 at 8:30 a.m. up in wheelchair eating breakfast, and 8/10/16 at 9:48 a.m. during a wound care observation.

The surveyor requested the current comprehensive care plan for Resident #6. The current comprehensive care plan dated 7/1/16 identified the problem of ADL (activities of daily living) Function/Dental. Resident #6 needs assistance with ADLs. He has contractures to his hands due to Rheumatoid Arthritis. He is up in a wheelchair daily which he self-propels with his feet. He is edentulous and does not wear dentures. Approaches: Provide shower/whirlpool 2 times a week and as needed, shave facial hair daily, provide daily dressing and grooming, assist with mouth care daily, provide good peri-care every 2 hours and as needed, keep skin clean and dry at all times, provide dressing and grooming with seasonal clothing, and therapies per md (doctor) order.

Systemic Changes:
The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process and the interdisciplinary team is responsible for managing the process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record, and physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-services to the RCC and care plan team on the mandate to develop individualized care plans within 7 days of the completion and/or revisions to the comprehensive assessment and as indicated with any changes in condition.

Monitoring:
The RCC and DON will be responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan schedule. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date: 9/21/16

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The current care plan did not direct the nursing staff in the use of the splints (when to apply, where to apply, how to long to apply, and when to remove) for Resident #6.

The surveyor interviewed the unit manager licensed practical nurse #9 on 8/10/16 at 3:30 p.m. L.P.N. #9 stated she thought the night shift staff applied the splints because he was up and moving during the day and would be more likely to remove them. The August 2016 treatment records were reviewed and splints were documented when they were applied and removed at night.

The surveyor interviewed minimum data set (MDS) licensed practical nurse #2 on 8/10/16. L.P.N. #2 stated she didn't think splints needed to be on the care plan. The surveyor re-interviewed L.P.N. #2 on 8/11/16 at 8:00 a.m. L.P.N. #2 stated the use of splints had been placed on the care plan and stated "They had been overlooked."

The surveyor informed the administrator, the director of nursing, the assistant director of nursing and the regional registered nurse consultant of the above finding on 8/11/16 at 12:15 p.m.

No further information was provided prior to the exit conference on 8/11/16.

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING — F 309

Each resident must receive and the facility must provide the necessary care and services to attain

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F 309	Continued From page 17	F 309		

or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to follow physician's orders for medication administration for 2 of 23 residents in the survey sample (Residents #12 and #19).

1. For Resident #12, facility staff failed to administer Culturelle for 30 days as ordered.

Resident #12 was admitted to the facility on 6/22/15 with diagnoses including hypertension, dementia, coronary artery disease, and obstructive uropathy. On a quarterly minimum data set (MDS) assessment with assessment reference date 6/15/16, the resident was assessed with long and short term memory impairment, moderate impairment in ability to make daily choices, scored 2/8 for signs of delirium, and was assessed with daily wandering.

During clinical record review on 8/10/16, the surveyor noted a physician order on 7/8/16 for Culturelle 2 capsules by mouth daily at bedtime for 30 days. The medication administration record documented the medication administered 7/9/16 through 8/7/16, for a total of 29 doses. There were medication or nurse's notes concerning the shortage.

The surveyor discussed the shortage with the

F309
Corrective Action(s):
Resident #12's attending physician was notified that the facility staff failed to administer Culturelle for 30days as ordered by the attending physician. A facility Incident and Accident form was completed for this incident.

Resident #19's attending physician was notified that the facility staff failed to administer Zocor as ordered by the physician. A facility Incident and Accident form was completed for this incident.

Identification of Deficient Practices/Corrective Action(s):
All other residents may have been potentially affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and the attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.

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F 309	Continued From page 18 director of nursing on 8/10/16. The DON acknowledged the resident received 29 doses. The shortage was discussed during a summary meeting with the administrator, director of nursing and a corporate consultant on 8/10/16. 2. For Resident #19, facility staff failed to administer Zocor one time daily as ordered by the physician. Resident #19 was admitted to the facility on 7/29/16 with diagnoses including subdural hematoma, peripheral artery disease, atrial fibrillation, and benign prostatic hypertrophy. On the admission minimum data set (MDS) assessment with assessment reference date 8/5/16, the resident scored 13/15 on the brief interview for mental status, and was assessed without signs of delirium or psychosis. During clinical record review on 8/11/16, the surveyor noted a physician order dated 7/29/16 for Zocor 40 milligram tablet by mouth daily. The medication administration record (MAR) for August 2016 documented Zocor 40 mg administered 8/1/16 at 9 AM and 9 PM. The surveyor was unable to locate reference to the extra dose in the MAR or nurse's notes. The surveyor discussed the error with the director of nursing and administrator during a summary meeting on 8/11/16.	F 309	**Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record and physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician medication & treatment orders. The DON and/or Regional nurse consultant will inservice all licensed staff on the procedure for obtaining, transcribing, and completing physician ordered medication and treatment orders. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Managers will audit all MAR's weekly to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 9/21/16	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315		

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resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to obtain physician orders for necessary indwelling catheter (Foley catheter) for 1 of 23 in the sample survey, Resident #16.
The Findings Included:
Resident #16 was a 93 year old male who was admitted on 7/27/16. Admitting diagnoses included, but were not limited to: rib fracture, pulmonary effusion, pneumothorax, hypertension, hypothyroidism, dementia and benign prostatic hyperplasia (BPH).
The most current Minimum Data Set (MDS) located in the clinical record was an Admission and 5 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 8/3/16. The facility staff coded that Resident #16 had a Cognitive Summary Score of 8. The facility staff also coded that Resident #16 required extensive assistance (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's).
On August 11, 2016 at 8:30 a.m. the surveyor reviewed Resident #16's clinical record. Review of the clinical record produced a hospital Discharge Summary dated 7/27/16 that documented that Resident #16 had : "10. BPH (benign prostatic hypertrophy) -No urinary

F315
Corrective Action(s):
Resident #16's attending physician was notified that the facility failed to obtain Foley Catheter care orders upon admission to the facility. A facility Incident & Accident report has been completed for this incident.

Identification of Deficient Practices & Corrective Action(s):
All other residents with a Foley Catheter may have potentially been affected. The DN, ADON or Unit Manager will review 100% of residents with a Foley Cather to ensure each resident has specific Foley catheter orders. Any/all negative findings identified will be corrected at the time of discovery. A facility Incident & Accident Form will be completed for each incident identified.

Systemic Change(s):
Reviewed current facility policy and procedure, no changes warranted at this time. All nursing will be inserviced by the DON ad/or ADON on the proper Foley catheter care orders to be implemented for all residents with a physician ordered Foley Catheter. To include Foley size, Bulb size, treatment to be provided if dislodged or clogged as well as routine daily care.

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symptoms -continue home meds (medications)-keep foley in due to trouble standing to urinate." (sic)
Further review of the clinical record produced a Physician Progress note dated 7/27/16. The Physician Progress Note documented: "Benign Prostatic Hypertrophy without obstruction Will clamp catheter and wean and D/c (discontinue) when we can." (sic)
Continued review of the clinical record produced nursing notes: "7/28/16 12:10 AM ...16 f (French) catheter in place and draining dark yellow urine ... " (sic)
The Foley catheter was discontinued on 7/29/16 at 2 p.m.
Continued review of the clinical record failed to produce physician orders for Foley catheter care lo include a Foley catheter size and bulb size, treatment if the Foley became dislodge or clogged and routine Foley catheter care.
On August 11, 2016 at 9 a.m. the surveyor at 10:20 the surveyor notified a Licensed Practical Nurse (LPN # 1) that Resident #16 had a Foley catheter on admission and that the Foley catheter was discontinued on 7/29/16. The surveyor notified LPN (#1) that review of the clinical record failed to produce physician orders to provide catheter care to Resident #16. The surveyor reviewed the clinical record with LPN (#1). The surveyor pointed out the hospital discharge summary, physician progress notes and the nursing notes. LPN (#1) reviewed the clinical record to see if she could locate physician orders for Foley catheter care. LPN (#1) stated, "They are not there."
On August 11, 2016 at 11:15 a.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Corporate Compliance Nurse

Monitoring:
The DON and ADON are responsible for maintaining compliance. DON, ADON or Unit Managers will complete post admission chart audits to monitor for compliance with routine Foley catheter care orders. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as necessary. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice.
Completion Date: 9/21/16

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	495371	A. BUILDING _____ B. WING _____	C 08/11/2016

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HERITAGE HALL-RICH CREEK	120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147

(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 315	Continued From page 21 (CCN). The surveyor notified the Administrative Team (AT) that Resident #16 had a Foley catheter on admission to the facility and that the facility staff did not obtain orders for routine care and treatment of the Foley catheter. On additional information was provided prior to exiting the facility as to why the facility staff failed to obtain physician orders for Foley catheter care for Resident #16.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to ensure an environment free of accident hazards for 1 of 23 Residents in the sample survey, Resident #8. For Resident #8, who had been identified at risk for falls, the facility staff failed to ensure that a physician ordered fall mat was in place. The Findings Included: Resident #8 was a 78 year old male, who was admitted on 3/12/16. Admitting diagnoses included, but were not limited to: stroke-acute ischemic, hypertension, Parkinson's, coronary artery disease and dementia. The most current Minimum Data Set (MDS)	F 323	**F323** **Corrective Action(s):** Resident #8's attending physician has been notified that facility staff failed to ensure a physician ordered fall mat was in place as ordered. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered fall mats or other preventive devices to prevent falls may have been potentially affected. The DON, ADON and/or Unit Manager will conduct a 100% review of all residents with physician ordered fall mats and fall prevention devices to identify residents at risk for inconsistent application of the equipment. 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.	

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F 323	Continued From page 22	F 323		

assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 6/22/16. The facility staff coded that Resident #8 had a Cognitive Summary Score of 6. The facility staff also coded that Resident #8 required total nursing care (4/3) with Activities of Daily Living (ADL's). In Section J. Health Conditions the facility staff coded that Resident #8 was at risk for falls. The facility staff also coded that Resident #8 had had 2 falls-with no injury.
On August 10, 2016 at 8:05 a.m. the surveyor observed Resident #8 lying in bed. The surveyor observed a fall mat rolled up and placed in a chair located to the right of the door entering Resident #8's room.
On August 10, 2016 at 8:30 a.m. the surveyor reviewed Resident #8's clinical record. Review of the clinical record produced signed physician orders dated 7/29/16. Signed physician orders included, but were not limited to: "Floor fall mate for safety." (sic) The order originated on 6/23/16.
Continued review of the clinical record produced the Comprehensive Care Plan (CCP). The surveyor reviewed of the CCP. The CCP identified the following "Problem/Need" and "Approaches." "Problem/Need: 6/24/16 Falls (name of Resident withheld) is at risk for fall r/t (related to) impaired mobility and judgement at times r/t dementia. Non-compliant with call bell at times. MX (multiple) falls over last qtr (quarter). HX (history) of getting up unassisted from bed/chair. Approaches: Fall ease mat beside bed." (sic)
On August 10, 2016 at 8:35 a.m. the surveyor observed Resident #8 lying in bed. The surveyor once again observed a fall mat rolled up and placed in a chair in Resident #8's room.
The surveyor observed a Licensed Practical

Systemic Change(s):
The facility policy and procedure for fall prevention and management has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all Licensed Nursing staff regarding proper use of and application of fall prevention equipments to include fall mats and wheelchair and bed alarms to prevent falls.

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or Unit Manager will perform daily inspections of all residents with physician order fall prevention devices to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken 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: 9/21/16

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F 323	Continued From page 23 Nurse (LPN #3) just outside of Resident #8's room. The surveyor notified LPN (#3) that Resident #8 was supposed to have a fall mat at the side of the bed. The surveyor notified LPN (#3) that the fall mat was rolled up and placed in a chair. The surveyor and LPN (#3) walked to Resident #8's room and the surveyor pointed out that the fall mat was rolled up and placed in the chair. LPN (#3) obtained the fall mat and placed the fall mat on the right hand side of the bed. On August 10, 2016 at 3:55 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #8 had a history of falls and had a physician order for a fall mat at the side of the bed. The surveyor notified the AT that the fall mat was observed rolled and placed in a chair in the room on two separate occasions. No additional information was provided prior to exiting the facility as to why the facility staff failed to implement physician ordered fall interventions for Resident #8.	F 323		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to obtain a physician order prior to obtaining laboratory tests for 3 of 23 residents (Resident	F 504		

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F 504	Continued From page 24	F 504		

#7, Resident #17, and Resident #22).

The findings included:

1. The facility staff failed to obtain a physician order prior to obtaining Vancomycin trough levels on Resident #7.

Resident #7's clinical record was reviewed 8/9/16 and 8/10/16. Resident #7 was admitted to the facility 8/21/15 with diagnoses that included but not limited to multiple sclerosis, traumatic amputation at knee level, seizures, heart failure, hypertension, colostomy, depressive disorder, gastroesophageal reflux disease, anemia, and abnormal posture.

Resident #7's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/27/16 assessed the resident with a brief interview for mental status as 14 out of 15.

During clinical record review of the laboratory section, a vancomycin trough level result was found dated 3/22/16.

The surveyor was unable to locate a physician order for the Vancomycin trough level completed 3/22/16. The surveyor requested the director of nursing ' s assistance to locate the order. The DON was unable to locate a physician order for the Vancomycin trough level. The surveyor reviewed the laboratory request form dated 3/22/16 provided by the DON. On the laboratory request form dated 3/22/16, in addition to Resident #7's confidential information, was written "v (check) trough." No specific trough level was ordered. A second lab request dated 3/23/16 read to check gentamycin trough.

F504
Corrective Action(s):
Resident #7's attending physician has been notified that the facility obtained a Vancomycin Trough level test without a physician order. A facility Incident & Accident form has been completed for this incident.

Resident #17's attending physician has been notified that the facility obtained a TSH lab test without a physician order. A facility Incident & Accident form has been completed for this incident

Resident #22's attending physician has been notified that the facility obtained CBC, CMP, Lipid panel, Vitamin D level, HgbA1C and a TSH lab tests without a physician order. A facility Incident & Accident form has been completed for this incident.

Identification of Deficient Practice(s) & Corrective Action(s):
All other residents may have potentially been affected. A 100% audit of resident clinical records will be completed to identify residents who may have had laboratory tests completed without a physician order. All negative findings will be corrected at the time of discovery and the attending physician will be notified. A Facility Incident & Accident form will be completed for each incident.

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Resident #7 had orders for Gentamycin but not orders for Vancomycin.

The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the regional registered nurse consultant of the above finding on 8/10/16 at 3:55 p.m.

No further information was provided prior to the exit conference on 8/11/16.

2. The facility staff failed to obtain a physician order prior to obtaining a TSH (thyroid stimulating hormone) level on Resident #17.

The clinical record of Resident #17 was reviewed 8/11/16. Resident #17 was admitted to the facility 7/28/16 and readmitted 8/10/16 with diagnoses that included but not limited to chronic respiratory failure, chronic combined systolic and diastolic heart failure, atrial fibrillation, pneumonitis, fibromyalgia, hypothyroidism, and obstructive sleep apnea.

Resident #17's 5 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/4/16 assessed the resident with a brief interview for mental status as 15 out of 15.

The laboratory section of the clinical record was reviewed. Laboratory results obtained on 8/4/16 were complete blood count (CBC), comprehensive metabolic panel (CMP), Magnesium level, and TSH (thyroid stimulating hormone).

The surveyor reviewed the signed admission physician orders for July 2016. A CBC, CMP, and

Systemic Changes:
The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced on the policy and procedure for obtaining resident laboratory tests, which includes obtaining a physician order prior to obtaining the lab test.

Monitoring:
The DON is responsible for maintaining compliance. The DON or ADON will review all lab tests results weekly to ensure that all resident lab tests obtained had an appropriate physician order for the lab tests prior to obtaining. Any negative findings will be reported to the attending physician and the appropriate disciplinary action taken for staff involved. 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: 9/21/16

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Mag (magnesium) level were ordered to be done 8/4/16.

The surveyor was unable to locate a physician order for the TSH obtained 8/4/16 as well.

The surveyor interviewed the unit manager licensed practical nurse #7 on 8/11/16 at 8:00 a.m. She reviewed the physician orders and stated she was unable to find an order for the TSH.

The corporate registered nurse informed the surveyor 8/11/16 at 8:35 a.m. that licensed practical nurse #1 had forgotten to write the order.

The administrative staff was informed of the above finding on 8/11/16 at 12:15 p.m.

No further information was provided prior to the exit conference on 8/11/16.

3. The facility staff failed to obtain a physician order prior to obtaining laboratory tests that were completed on 6/27/16 for Resident #22.

The clinical record of Resident #22 was reviewed 8/11/16. Resident #22 was admitted to the facility 6/22/16 with diagnoses that included but not limited to type 2 diabetes mellitus, metastatic liver cancer, edema, hypertension, hyperlipidemia, hypothyroidism, Alzheimer's disease, dementia without behavioral disturbances, dysphagia, and gastroesophageal reflux disease.

Resident #22's admission (5 day) minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/29/16 assessed the

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F 504	Continued From page 27 resident with a cognitive summary score of 07 out of 15. The laboratory section of the clinical record was reviewed. On 6/27/16 labs were obtained that included a CBC (complete blood count), CMP (comprehensive metabolic panel), lipid profile, Vitamin D level, Hemoglobin A1C, and TSH (thyroid stimulating hormone). The surveyor reviewed the June 22, 2016 signed physician orders and the June 2016 telephone orders but was unable to locate the physician order for the labs. The surveyor requested the assistance of the unit manager licensed practical nurse #7 on 8/11/16 at 10:00 a.m. L.P.N. #7 reviewed the clinical record for the physician order for the labs and stated she was unable to locate the order then stated "L.P.N. #1" usually takes care of the labs. The surveyor informed the administrative staff of the above finding on 8/11/16 at 12:15 p.m. No further information was provided prior to the exit conference on 8/11/16.	F 504		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		

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F 514 Continued From page 28

information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to maintain complete and accurate bowel movement records in the clinical record for 1 of 23 residents (Resident #3).

The findings included:

The facility staff failed to document bowel movements in the clinical record for Resident #3.

The surveyor reviewed Resident #3's clinical record on 8/9/16 and 8/10/16. Resident #3 was admitted to the facility 9/20/13 with diagnoses that included but not limited to Lewy Body dementia, dyspnea, degenerative disease of nervous system, osteoporosis, osteoarthritis, left and right knee contractures, hypertension, and major depressive disorder.

Resident #3's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/22/16 assessed the resident with a cognitive summary score of 09 out of 15. Bowel and Bladder (Section H) assessed the residents as always incontinent of bowel and bladder.

The surveyor reviewed the bowel movement records from June 2016 through August 2016.

F 514

F514
Corrective Action(s):
Resident #3's attending physician has been notified that the facility staff failed to maintain a complete and accurate bowel movement record within the medical record. A facility incident and accident form has been completed for this incident.

Identification of Deficient Practices & Corrective Action(s):
All other residents may have potentially been affected. A 100% audit of resident's medical records for the last 30 days will be conducted by the DON, ADON and/or Medical records to identify residents at risk for incomplete and inaccurate bowel movement documentation. All negative findings will be clarified and/or correct as applicable at time of discovery. A facility Incident & Accident form will be completed for each negative finding.

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From 6/20/16 through 6/24/16 (5 days), there was no documentation in the electronic clinical record of bowel movements for Resident #3. From 7/22/16 through 7/25/16 (4 days), there was no documentation in the clinical record of bowel movements for Resident #3. From 7/28/16 through 8/1/16 (5 days), there was documentation that Resident #3 had bowel movements.

The surveyor informed the unit manager licensed practical nurse #9 of the above concern. The surveyor and the unit manager reviewed the electronic bowel movement record. L.P.N. #9 stated the 24 hour report had a column for bowel movements and she provided the 24 hour reports for the above date range. L.P.N. #9 stated the 24 hour report was not in the clinical record and the bowel movement column was added to the 24 hour report to ensure bowel movements were done.

The surveyor informed the administrative staff of the above finding on 8/11/16 at 12:15 p.m.

No further information was provided prior to the exit conference on 8/11/16.

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. All nursing staff will be inserviced by the DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include complete and accurate documentation of bowel movement information in the medical record to the acceptable professional standards and practices.

Monitoring:
The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager 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: 9/1/16