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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/21/16 through 9/23/16. One complaint was investigated during the survey process. Significant 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 40 certified bed facility was 38 at the time of the survey. The survey sample consisted of 11 current Resident reviews (Residents 1 through 9 and 11 through 12) and 1 closed record reviews (Resident 10).	F 000	**The submission of the Plan of Correction does not constitute agreement on the part of Shenandoah Valley Westminster-Canterbury that the deficiencies cited within the report represent deficient practices on the part of Shenandoah Valley Westminster Canterbury. This plan represents our on-going pledge to provide quality care that is rendered in accordance with all regulatory requirements.**	
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	F 278	F-Tag 278 **1. Corrective Action** A note was entered into PCC for Resident #3 during the MDS process that stated the reason behind not interviewing the resident. The corrective action will also address ongoing efforts and how to handle residents who are normally able to speak for themselves. **2. Other Potential Residents** All residents with a comprehensive or quarterly MDS are potentially affected. A complete audit on residents current MDS sections C, D was completed on 9/22/16. Multiple attempts will be made with residents at different times of day and days of the week to complete the interview before an MDS submission.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	10/14/16

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

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resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for one of 12 residents in the survey sample, Resident #3.

The facility staff failed to code whether or not a brief interview for mental status (BIMs) should be conducted on Section C Cognitive Patterns, of the MDS assessment and the facility staff failed to code whether or not a resident mood interview should be conducted on Section D, Mood.

The findings include;

Resident #3 was admitted to the facility on 9/9/15 with diagnoses that included, but were not limited to; high blood pressure, dementia, depression, cataracts on the eyes, glaucoma (a disease of the eyes causing blindness) and hypothyroidism (a low functioning thyroid gland).

Resident # 3's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 9/17/16, did not contain a BIMs (brief interview of mental status) for Resident #3, the facility staff did complete a staff assessment completed in

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3. Systems Change
All disciplines entering data on the comprehensive and/or quarterly MDS will be re-educated on the instructions of the RAI manual for sections C and D by 11/4/16. The Director of Resident Services (DoRS) will review all MDS sections C and D prior to attestation signature of completion. The RN who signs the MDS at completion will ensure the coding of a BIMS on section C, Cognitive Patterns, as well as the coding for resident mood interview on section D, Mood.

4. Monitoring
All comprehensive and/or quarterly MDS assessments, section C and D, will be reviewed upon completion by the DoRS to ensure BIMS and/or Mood interviews were conducted and coded appropriately. Report of findings will be submitted to the QAPI committee.

5. Date
Corrective action will be completed by 11/06/2016.

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Section C0600 which coded Resident #3 as moderately impaired in cognitive skills for daily decision making.

Further review of Resident #3's MDS assessment with an ARD of 9/17/16 did not indicate whether or not Resident #3 was able to be interviewed for Section D, Mood, D0100 through D0300 contained dashes for each entry. The staff completed a staff assessment for mood.

Further review of Resident #3's MDS assessment with an ARD of 9/17/16 revealed in Section B, Hearing, Speech and Vision, coding of "0" (zero) in sub-sections B0700 and B0800, indicating that Resident #3 was understood and was able to understand others.

On 9/22/16 at 2:40 p.m. an interview was conducted with OSM (other staff member) #5, the social worker. OSM #5 was asked which sections of the MDS assessment she was responsible for completing. OSM #5 stated that she was responsible for Sections C, D, E and Q. OSM #5 was asked whether or not she conducted interviews with the residents. OSM #5 stated, "I make an attempt to interview Residents." OSM #5 was asked what circumstances would she not interview a resident. OSM #5 stated, "If the resident was unable to be interviewed, in a coma or lethargic. If a resident is unable to complete the interview I may go back a few times." OSM #5 was asked how Sections C and D should be coded. OSM #5 stated that she would code based on whether or not the resident could answer the interview questions. OSM #5 was provided a copy of Resident #3's significant change MDS with an ARD of 9/17/16, Section C, Cognitive Patterns, and Section D, Mood, and

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was asked whether or not an interview had been attempted with Resident #3. OSM #5 stated, "I should have coded a "1" (yes) to the question in regards to conducting an interview of the resident for mental status and mood." OSM #5 was asked what the dashes meant that were entered in Sections C and E. OSM #5 stated that she did not know, she should have put a "1" and then the summary score should have been "99" for both sections indicating that the resident was unable to complete the interviews.

The following instructions for coding the resident' BIMs and Mood are provided in the RAI (resident assessment manual):

Coding Instructions
Record whether the cognitive interview should be attempted with the resident.
· Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.
· Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.
CMS's RAI Version 3.0 Manual CH 3: MDS Items [C] May 2013 Page C-2
C0100: Should Brief Interview for Mental Status Be Conducted? (cont.)
Coding Tips
· If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview

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not attempted and complete C0700-C1000, Staff Assessment of Mental Status, instead of C0200-C0500, Brief Interview for Mental Status.
· Includes residents who use American Sign Language (ASL).

D0100: Should Resident Mood Interview Be Conducted?
Steps for Assessment
1. Determine if the resident is rarely/never understood. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).
2. Review Language item (A1100) to determine if the resident needs or wants an interpreter to communicate with doctors or health care staff (A1100 = 1).
· If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions
· Code 0, no: if the interview should not be conducted. This option should be selected for residents who are rarely/never understood, or who need an interpreter (A1100 = 1) but one was not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9- OV©).
· Code 1, yes: if the resident interview should be conducted. This option should be selected for residents who are able to be understood, and for whom an interpreter is not needed or is present. Continue to item D0200, Resident Mood Interview (PHQ-9©).

A review of the facility policy titled "Resident Assessment using the Minimum Data Set (MDS 3.0) / Resident Instrument" revealed, in part, the following information: "The RAI helps nursing home staff gather definitive information on a

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F 278	Continued From page 5 resident's strengths and needs, which must be addressed in an individualized care plan. The RAI helps nursing home staff look at residents holistically. The RAI simply provides a structured standardized approach for applying a problem identification process in nursing homes. At an end of day meeting on 9/22/16 at 4:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings. No further information was presented prior to the end of the survey process.	F 278		
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 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.	F 280	F-Tag 280 **1. Corrective Action** On 9/23/16, the Nurse Practitioner (NP) completed a wound assessment evaluation and treatment plan for the pressure injury on the left heel of Resident #7. The care plan for Resident #7 was reviewed and updated on 9/23/16 for the pressure injury to the left heel. Resident #1 had a contributing factor of Anemia related to the 5/28/16 fall with decision of comfort care following. The care plan for Resident #1 was reviewed and updated on 6/12/16. After the fall on 7/4/16, Resident #1's care plan was reviewed and updated on 7/5/16 with the intervention of a body pillow for comfort and positioning. **2. Other Potential Residents** All residents are at risk for falls. A audit of each care plan for residents having had a fall or pressure ulcer will be reviewed and updated. A Fall Risk Assessment is completed on all residents upon admission to healthcare, after each fall and quarterly. Any found not in compliance will be updated as appropriate.	

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F 280	Continued From page 6 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 review and revise the comprehensive care plan for two of 12 residents in the survey sample, Residents #7, and #1. 1. The facility staff failed to review and revise the comprehensive care plan for Resident #7 for a new pressure ulcer on her heel. 2. The facility staff failed to review and revise the comprehensive care plan for Resident #1 following two falls that occurred on 5/28/16 and 7/4/16. The findings include: 1. Resident #7 was admitted to the facility on 10/30/13 with a readmission on 9/28/15 with diagnoses that included but were not limited to: Alzheimer's disease, scoliosis (curvature of the spine (1)), diabetes, high blood pressure, osteoarthritis, atrial fibrillation (rapid and random contractions of the heart (2)), and edema. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 9/17/16, coded the resident as scoring a "six" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for	F 280	3. Systems Change Nursing staff who encountered an accident/injury will complete a "grab/go" care plan with interventions to update the current care plan. The Falls Committee will review weekly the care plan updates. Staff will receive education on the Pressure Ulcer policy that addresses the prevention and treatment plan of pressure ulcers. The Unit Coordinator (UC) or designee can assign tasks to the POC (Point of Care) for the front line staff to be informed of any care plan changes. 4. Monitoring The Falls Committee meets weekly to review all falls. An analysis of each fall will be reviewed for any trends/patterns. The UC or designee will bring a working copy of the care plan to the meeting for review and appropriate and timely updates. The chairperson will receive a copy of the care plan updates weekly. The Wound Committee will assess and review all wounds and ensure proper updates to the care plan after each assessment/evaluation. An analysis of each wound will be reviewed for any trends/patterns. Data from each committee on falls and wounds will be reported to the QAPI committee. 5. Date Corrective action will be completed by 11/06/2016.	

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all of her activities of daily living, except eating in which she required limited assistance of one staff member.

Upon entrance, on 9/21/16, the director of health services informed the survey team, the facility did not have any pressure ulcers at present.

Resident #7 was observed during the medication administration observation conducted on 9/22/16 at 9:12 a.m. LPN (licensed practical nurse) #3 entered the room with the resident's medications. She spoke with the resident and was assisting the resident to reposition so she could raise the head of the bed and administer her medications. Resident #7's left heel was observed resting directly on the surface of the bed, despite the presence of one pillow under her calves. LPN #3 went to lift the resident's left leg to reposition it. Resident #7 moaned and stated, "My heel really hurts, it's so painful." When LPN #3 lifted the left leg, a black spot approximately the size of a dime, was observed on the resident's left heel. LPN #3 stated, "There should be a dressing on that." When asked if the spot on Resident #7 ' s heel was a pressure ulcer, LPN #3 stated, "Yes."

The clinical record was reviewed.

A note dated, 9/19/19 at 4:25 p.m. by the nurse practitioner documented, "Wound to L (left) heel evaluated. It is 0.75 cm (centimeters) in diameter. Tissue is pale yellow, white, dry, there is no erythema, heat or drainage. Tender to touch. Edges are even. Apply Santyl (Santyl is a sterile enzymatic debriding ointment that has a unique ability to digest collagen in necrotic tissue (3)) daily with Mepitel border (dressing). Keep

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elevated to avoid pressure. dx (diagnosis) Stage 2 pressure ulcer, L heel."

Stage 2 pressure injury - Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis, medication adhesive related skin injury or traumatic wounds (skin tears, burns abrasions). (4)

The comprehensive care plan, dated, 8/6/16, documented in part, "Focus: (Name of Resident #7) has potential for impairment to skin integrity r/t (related to) fragile skin, use/side effects of medications/treatments she is ordered." The "Interventions" documented in part, "Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration, etc. to MD (Medical Doctor)." The care plan dated, 7/27/15 and revised on 6/25/16, documented in part, "(Name of Resident #7) is at risk for pressure ulcer development r/t occasional urinary incontinence and needing assistance, at times, with bed mobility." The "Interventions" documented in part, "Administer treatments as ordered and monitor for effectiveness. Avoid positioning (Resident #7) on boney areas. (Resident #7) needs reminding/assistance at times to turn/reposition at least every 2 hours,

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more often as needed or requested, with the use of the ordered 1/2 upper side rails. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Licensed nurses perform a weekly skin assessment on her bath day and document any signs of skin breakdown, including skin tears, bruising, maceration, rashes, and reddened areas. NP is notified of any reddened areas- especially if located over a bony prominence. She has a specialized alternating air mattress on her bed to help redistribute potential pressure areas. Insure (sic) it is functioning properly every shift."

There was no documentation in the comprehensive care plan related to an actual pressure area on the left heel.

An interview was conducted with administrative staff member (ASM) #2, the director of health services, on 9/23/16 at 8:30 a.m. When asked if an actual pressure ulcer should be on the care plan, ASM #2 stated, "Yes." ASM #2 was asked when a care plan should be updated after the identification of a new pressure ulcer. ASM #2 stated, "As soon as it is identified as an actual pressure ulcer."

An interview was conducted with LPN (licensed practical nurse) #5, the unit coordinator, on 9/23/16 at 11:35 a.m. When asked if the care plan should be updated when a resident develops a new pressure ulcer, LPN #5 stated, "Yes, but I'm the only one doing that."

A review of the facility policy titled "Care Plan, Comprehensive" documented, in part, the following information; "Policy; The facility must develop a comprehensive care plan for each

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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. Procedure: The plan is periodically reviewed and revised by a team of qualified persons after each assessment. The resident and / or families are involved in care planning and updating to the extent possible." There was no documentation that described review and revision of resident care plans following changes in condition.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

The administrator and ASM #2 were made aware of the above concern on 9/23/16 at 11:40 a.m.

No further information was provided prior to exit.

(1) Barron's Medical Guide - Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 523.
(2) Barron's Medical Guide - Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55.
(3) This information was taken from the following

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website: http://www.rxlist.com/santyl-drug.htm.
(4) This information was taken from the following website:
www.npuap.org/resources/educational-and - clinical - resources/npuap-pressure-injury-stages.

2. The facility staff failed to review and revise the comprehensive care plan for Resident #1 following two falls that occurred on 5/28/16 and 7/4/16.

Resident #1 was admitted to the facility on 10/8/15 with diagnoses that included, but were not limited to; heart disease, dementia, high blood pressure, glaucoma (a disease of the eyes causing blindness), failure to thrive, and depression.

Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/13/16, coded Resident #1 as scoring 10 out of a possible 15 on the BIMs (brief interview for mental status), indicating Resident #1 was moderately impaired with daily decision making.

A review of Resident #1's clinical record revealed that Resident #1 had fallen on two occasions while a resident at the facility. The falls occurred on 5/28/16 and 7/4/16.

A review of Resident #1's comprehensive care plan dated 8/8/14 did not reveal any documentation in regards to either fall on 5/28/16 and 7/4/16.

On 9/22/16 at 2:40 p.m. an interview was conducted with LPN (licensed practical nurse) #5, the unit coordinator. LPN #5 was asked who was

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F 280	Continued From page 12 responsible for review and revision of the comprehensive care plans. LPN #5 stated that she was. LPN #5 was asked to describe when a care plan would be reviewed for revision. LPN #5 stated, "I would update a care plan for new orders, a significant change, any new interventions, skin tears etc.," LPN #5 was asked what she considered a reasonable time frame to review and revise a care plan following a change in a resident's condition or care needs. LPN #5 stated, "I would think 3-5 days would be reasonable to complete an update." LPN #5 was asked to describe the purpose of a care plan, LPN #5 stated, "It is to make sure staff are aware of how to care for the resident, to meet individualized goals." LPN #5 was asked to review Resident #1's care plan. LPN #5 was then asked whether or not the care plan should have been revised following Resident #1's falls. LPN #5 stated, "There should be a documented intervention after each fall." On 9/22/16 at 4:10 p.m. an end of day meeting was held with ASM (administrative staff member) #1, the administrator and ASM #2, the director of health services. Both ASM #1 and ASM #2 were made aware of the above findings. ASM #2 was asked when care plans were to be reviewed and revised. ASM #2 stated, "Care plans are reviewed quarterly and revised on an ongoing basis based on changes in the individualized care needs." No further information was provided prior to the end of the survey process.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309	F Tag 309 1.Corrective Action For resident #6, the attending primary provider was notified on 9/22/16 of the administration of the medication outside the ordered parameters for the blood pressure. The order was clarified with parameters without the use of symbols. The electronic record requires the supplemental documentation of the blood pressure readings prior to administration. There were no ill effects to Resident #6.	

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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, facility document review, and clinical record review, it was determined that the facility staff failed to follow physician orders for one of 12 residents in the survey sample, Resident #6.

The facility staff administered a blood pressure medication when the blood pressure was outside of the physician prescribed parameters for Resident #6.

The findings include:

Resident #6 was admitted to the facility on 3/28/16 with diagnoses that included but were not limited to: Parkinson's disease, retention of urine, cardiac arrhythmia, colostomy, gastroesophageal reflux disease, dementia, and low blood pressure.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/17/16, coded the resident as being severely impaired to make daily cognitive decisions. Resident #6 was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of his activities of daily living.

The physician order dated, 8/29/16, documented, "Fludrocortisone Acetate Tablet (used to treat

2. Other Potential Residents
All residents prescribed medications requiring parameters are potentially affected. The MAR (Medication Administration Records) will be audited by 10/14/16 for blood pressure medications with parameters to ensure physician orders were followed.

3. Systems Change
Licensed staff will be re-educated on medication administration protocols, specifically blood pressure medications and parameters. Education will include proper medical terminology, avoiding the use of symbols and re-education on the use of the electronic record for orders with supplemental documentation and parameters.

4. Monitoring
The night shift nurse will run a vital sign report (blood pressures) daily for all residents taking blood pressure medications with parameters. This will ensure the administration of medication is cross referenced to the blood pressure readings within the ordered parameters. Any findings will be reported to the DoHS who will report to the QAPI committee.

5. Date
Corrective action will be completed by 11/06/2016

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Addison's disease and for the treatment of salt-losing adrenogenital syndrome.(1)) 0.1 MG (milligram); Give 1 tablet by mouth two times a day related to other hypotension (too low blood pressure), give every 12 hours. HOLD for SBP (systolic blood pressure) > (greater than) 120 or DBP (diastolic blood pressure) > 86."

The eMAR (electronic medication administration record) documented, "Fludrocortisone Acetate Tablet 0.1 MG; Give 1 tablet by mouth two times a day related to other hypotension, give every 12 hours. HOLD for SBP > 120 or DBP >86."

The eMAR documented the following dates and times when the Resident #6's blood pressure readings were outside of the physician prescribed parameters and the medication was administered:
9/5/16 - 8:00 a.m. - 132/70
9/8/16 - 8:00 a.m. - 122/64
9/15/16 - 8:00 a.m. - 122/70
9/20/16 - 8:00 a.m. - 132/75
9/21/16 - 8:00 a.m. - 138/80
9/22/16 - 8:00 a.m. - 140/72

Review of the nurse's notes did not reveal any documentation regarding the medication or the blood pressure readings.

The comprehensive care plan dated, 11/10/14 and revised on 7/24/16, documented, "Focus: (Resident #6) is risk for falls r/t (related to) indwelling Foley cath (catheter) use, antidepressant use, Parkinson's DX (diagnosis), Hypotension DX, Hypokalemia DX (too low potassium in blood), and requiring staff assistance for most to all ADL's (activities of daily living)." The "Interventions" documented in part,

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"Administer Medication as order by the MD (medical doctor) and eval (evaluate) for S/Sx (signs and symptoms) of adverse effects and side effects of medication use. Check blood pressure Q (every) day and record in the E-chart (electronic medical record), Notify MD (Medical Doctor) of abnormalities."

An interview was conducted with LPN (licensed practical nurse) #4 on 9/22/16 at 9:36 a.m. LPN #4 was asked if a physician has ordered parameters for the administration of certain medications, what actions a nurse should take when administering the medication. LPN #4 stated, "You follow the parameters as they are written by the doctor." LPN #4 was asked to review the above physician order. After reviewing the physician order, LPN #4 stated, "If I get either one, greater than 120 or greater than 86, I hold the medication." When asked if staff notifies the physician when a medication is held, LPN #4 stated, "Only if the order says to notify the doctor. We don't routinely notify them for held medications based on their prescribed parameters." This nurse, LPN #4 had administered the medication three times on the dates documented above when Resident #6's blood pressure reading was outside of the prescribed parameters.

An interview was conducted with RN (registered nurse) #2 on 9/22/16 at 1:22 p.m. RN #2 was asked to review the above order. RN #2 stated, "I know what this is. I really got 120 but accidentally put it in the computer as 122." RN #2 was asked to review the parameters for the medication. RN #2 stated, "Usually the parameters are for blood pressures less than a prescribed number, not for above." This nurse administered two of the doses

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on the dates documented above when Resident #6's blood pressure readings were outside the physician ordered parameters for administering the medication. At this time it was verified with RN #2 that the medications should not have been given on the days that she administered them.

An interview was conducted with administrative staff member (ASM) #2, the director of health services) on 9/22/16 at 2:30 p.m. ASM #2 was asked to review the physician documented order above. After reviewing the physician order, ASM #2 stated, "There's a problem with this order. We should spell out the greater than sign." When asked if the medication should have been given on the above documented dates, ASM #2 stated, "No, it should have been held."

The facility policy, "Medication Administration General Guidelines" documented in part, "29. For medication that requires blood pressure (BP) parameter, these parameters are charted in the MAR (medication administration record)."

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."

The administrator and director of health services were made aware of the above concern on 9/22/16 at 4:20 p.m.

No further information was provided prior to exit.

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F 309	Continued From page 17 (1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=198278e7-9a6d-4a9a-bb47-3589f35939da	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 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 assess and monitor pressure injury areas for one of 12 residents in the survey sample, Resident #7. a. The facility staff failed to assess, and monitor the "boggy" areas on Resident #7's heel as a pressure ulcer. failed to complete weekly and failed to elevate the resident's heels as ordered by the physician. b. The facility staff failed to assess and monitor Resident #7's buttocks for a pressure injury area that progressed to a pressure ulcer.	F 314	F-Tag 314 **1. Corrective Action** Resident #7 expired on 9/24/16. **2. Other Potential Residents** All residents who have limited mobility are at risk for impaired skin integrity, disease process, incontinence, etc. are potentially affected. All residents are scheduled for weekly non-pressure skin assessments. **3. Systems Change** Licensed staff will be re-educated on the prevention and stages of pressure ulcers. Re-education will include the use of the "grab and go" care plan for impaired skin integrity. Any findings of impaired skin from the weekly assessments will be reported to the NP or PCP for further assessment and documentation. A Wound Committee will be implemented by November 2, 2016, consisting of the NP, DoHS, front line nurse, front line CNA and dietician. The committee will review all wounds requiring initial and weekly assessments to evaluate the healing of the wound. During the daily stand up meetings beginning on 10/19/16, focused discussions will also include those residents due for weekly non- pressure skin assessments and any findings.	

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F 314	Continued From page 18	F 314	4. Monitoring All non-pressure weekly skin assessments will be audited weekly by the UC/designee to: ensure completion of all skin observations by checking the user defined reporting of EMR; follow-up any discrepancies and report results to the DoHS or designee. Weekly, the Wound Committee will: audit the etiology of the wound through incident reporting analysis; identify any trends/patterns; ensure report completion, accuracy and proper documentation for all pressure injuries. Findings will be reported to the QAPI committee. 5. Date Corrective Action will be completed by 11/06/2016.	

The findings include:

a. Resident #7 was admitted to the facility on 10/3013 with a readmission on 9/28/15 with diagnoses that included but were not limited to: Alzheimer's disease, scoliosis (curvature of the spine (1)), diabetes, high blood pressure, osteoarthritis, atrial fibrillation (rapid and random contractions of the heart (2)),, and edema.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 9/17/16, coded the resident as scoring a "six" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living, except eating in which she required limited assistance of one staff member.

Resident #7 was observed during the medication administration observation conducted on 9/22/16 at 9:12 a.m. LPN (licensed practical nurse) #3 entered the room with the resident's medications. She spoke with the resident and was assisting the resident to reposition so she could raise the head of the bed and administer her medications. Resident #7's left heel was observed resting directly on the surface of the bed, despite the presence of one pillow under her calves. LPN #3 went to lift the resident's left leg to reposition it. Resident #7 moaned and stated, "My heel really hurts, it's so painful." When LPN #3 lifted the left leg, a black spot approximately the size of a

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dime, was observed on the resident's left heel. LPN #3 stated, "There should be a dressing on that." When asked if the spot on Resident #7's heel was a pressure ulcer, LPN #3 stated, "Yes."

The clinical record was reviewed.

A "Braden Scale for Predicting Pressure Sore Risk" dated; 6/24/16 documented Resident #7 was a "moderate risk" for developing pressure ulcers.

The "Weekly Non Pressure Skin Assessment" dated, 8/7/15, failed to document any concern on the resident's heels.

The nurse's note dated, 8/8/16 at 1:26 p.m. documented, "New orders noted r/t (related to) bilateral boggy heels. Sure prep (used to provide a protective barrier on skin (3)) BID (twice a day) and float heels when in bed or recliner."

A stage 1 pressure injury: intact skin with a localized area of non-bleachable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury." (4)

There was no documentation of the size of the area or any wound tracking documentation.

The physician orders dated, 8/8/16, documented, "Sure Prep to bilateral heels two times a day for soft boggy bilateral heels. Float bilateral heels when in bed or recliner chair."

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There were no physician/nurse practitioner notes from 7/26/16 through 8/10/16. The 8/10/16 nurse practitioner note was related to a change in Coumadin dose, and not related to the resident's heel.

The "Weekly Non Pressure Skin Assessment" dated, 8/14/16, documented, "Skin warm, dry and intact. No new skin issues noted. Preventive measures in place."

The "Weekly Non Pressure Skin Assessment" dated, 8/21/16, documented, "Skin dry and intact, BLE (bilateral lower extremities) edema noted. Placed in MD (medical doctor) book for f/u (follow up)."

The nurse practitioner note dated, 8/22/16, documented, "Hold Coumadin (a blood thinner) for 3 days." There was no documentation of an assessment of Resident #7's heel.

The "Weekly Non Pressure Skin Assessment" dated, 8/28/16, documented, "Skin warm, dry and intact. No new skin issues noted. Preventive measures in place."

The August eTAR (electronic treatment administration record) dated 8/8/16, documented, "Sure prep to bilateral heels two times a day for soft boggy bilateral heels." It was documented as having been administered 8/8/16 through 8/31/16 as ordered.

The next documentation related to Resident #7's heel occurred on 9/4/16 at 11:26 a.m. The nurse documented, "Staff went in to get resident up and ready for her shower and noticed blood on her sock. Upon removing sock she noted that

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resident skin had sloughed off. Resident is receiving skin prep to bilateral heels BID and skin was tough. Area to left heel measures 2 cm (centimeters) x (by) 1.5 cm. Dressing applied as per order. Will continue to monitor."

The "Weekly Non Pressure Skin Assessment" dated, 9/4/16 documented, "Left heel - open area to heel 2 cm x 1.5 cm, dressing in place."

The physician orders dated, 9/4/16 documented, "Clean left heel with soap and water, pat dry, apply bacitracin to affected area, cover with nonstick pad and wrap with cling every day shift for 2 administrations."

The nurse practitioner's note dated, 9/7/16 at 4:37 p.m. documented, "Skin tear to L (left) heel. I have reviewed with nurse (first name of LPN #3) and staff will treat per skin tear protocol."

A nurse's note dated 9/11/16 at 3:40 p.m. documented, "Residents left heel dressing changed this shift. Resident having much pain while touching heel. She cries out in pain, 8/10 (a numeric pain scale from zero to ten, ten indicating the worse pain ever experienced) voiced. Area not healing redressed and heel cup placed on heel for cushioning and heel raised off surface. Msg (message) in physician's communication book for assessment of heel and tx (treatment) needed. Resident given MS (morphine sulfate) (a narcotic used to treat moderate to severe pain (5)) for pain voiced 8/10 with voiced relief. Daughter in and expressed that she has seen decline in health over past few weeks. Assured daughter that facility would keep resident comfortable as directed by physician and NP (nurse practitioner)."

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The "Braden Scale for Predicting Pressure Ulcer Sore Risk" dated, 9/16/16, documented Resident #7 was at "high risk" for developing pressure ulcers.

The "Weekly Non Pressure Skin Assessment" dated, 9/18/16, documented, "Left heel - area remain to left heel appox (sic) (approximately) 2 cm (centimeters) x 2.5 cm, slight drainage noted on old bandage. Area cleansed with soap and warm H20 (water) and new dressing applied."

There was no "Weekly Non Pressure Skin Assessment" done between 9/4/16 and 9/18/16.

The next note related to Resident #7's left heel in the clinical record was dated, 9/19/19 at 4:25 p.m. The nurse practitioner documented, "Wound to L heel evaluated. It is 0.75 cm in diameter. Tissue is pale yellow, white, dry, there is no erythema, heat or drainage. Tender to touch. Edges are even. Apply Santyl (Santyl is a sterile enzymatic debriding ointment used for its unique ability to digest collagen in necrotic tissue (6)) daily with Mepitel border (dressing). Keep elevated to avoid pressure. dx (diagnosis) Stage 2 pressure ulcer, L (left) heel."

Stage 2 pressure injury - Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture

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associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis, medication adhesive related skin injury or traumatic wounds (skin tears, burns abrasions). (7)

The physician order dated, 9/19/16 documented, "Cleanse left heel with mild soap and H2O. Apply Santyl Collagenases to necrotic bed avoiding good skin. Cover with Mepore daily and PRN (as needed) every day shift for left heel wound."

A request was made to administrative staff member (ASM) #2, the director of health services, on 9/23/16 at 10:27 a.m. for all of the physician/nurse practitioner progress notes from 8/1/16 through 9/22/16. ASM #2 provided all of the physician/nurse practitioner notes on 9/23/16 at approximately 11:00 a.m. There was no progress note between 9/11/16 through 9/19/16.

The nurse's notes documented on 9/20/16 at 5:58 p.m. the administration of Morphine Sulfate for, "facial grimacing during left heel dsg (dressing) change."

The eTAR for September documented the following treatments:
"9/4/16 - Clean left heel with soap and warm water; pat dry, apply bacitracin to affected area, cover with nonstick pad and wrap with cling every day shift for 2 administrations." It was documented as having been administered on 9/4/16 and 9/5/16.
"9/20/16 - Cleanse left heel with mild soap and H2O. Apply Santyl Collagenases to necrotic bed avoiding good skin. Cover with Mepore daily and PRN (as needed) every day shift for left heel

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wound." This was signed off as being administered on 9/20/16.
"8/8/16 - Sure prep to bilateral heels two times a day for soft boggy bilateral heels." This was documented as being administered 9/1/16 through 9/19/16 when the order was changed to just the right heel.

There were no other treatments documented on the eTAR for the treatment of Resident #7's left heel.

The physician order dated, 9/21/16, documented, "Cleanse left heel with mild soap and H2O. Apply Santyl Collagenase to necrotic bed avoiding good skin. Cover with Mepore daily and PRN every day shift every other day for left heel wound."

The nurse practitioner note dated, 9/22/16 at 10:50 a.m. documented, "Pressure ulcer to L heel assessed. This has progressed from skin tear to stage 2 pressure ulcer and is now unstageable due to presence of necrosis. Ulcer today is 1.5 x 2 cm. Edges are smooth, bed is dry eschar. Area is tender. Donut cushion on ankle to keep heel elevated. The surrounding tissue is without heat, erythema or swelling. There is no drainage present. Dietary consulted on resident. Dx (diagnosis): unstageable pressure ulcer, with necrosis, continue Santyl and dressing change qod (every other day). Administer MS (morphine sulfate) 0.25ml/5 mg (milligrams) 30 minutes prior to dressing change. Labs (laboratory tests) not recommended as resident has been declining over last 2 months and is comfort care."

The following new physician orders were put in place on 9/22/16:
When up in recliner chair or wheelchair please

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float heel off any surface
Unstageable pressure ulcer to left heel. Cleanse left heel with soap and H2O (water). Pat dry, Apply Santyl to necrotic bed avoiding good skin. Cover with Mepore (dressing)
Dietary consult r/t pressure ulcer left heel.
Pressure ulcer care - turn and reposition every 2 hours related to Pressure Ulcer of Left heel, Unstageable.
Morphine Sulfate solution 20 mg/ml (milligrams/milliliter); give 0.25 ml by mouth in the evening related to PRESSURE ULCER OF LEFT HEEL, UNSTAGEABLE to be given 30 minutes prior to left heel dressing change.

The comprehensive care plan, dated, 8/6/16, documented in part, "Focus: (Resident #7) has potential for impairment to skin integrity r/t (related to) fragile skin, use/side effects of medications/treatments she is ordered." The "Interventions" documented in part, "Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration, etc. to MD (medical doctor)." The care plan dated, 7/27/15 and revised on 6/25/16, documented in part, "(Name of Resident #7) is at risk for pressure ulcer development r/t occasional urinary incontinence and needing assistance, at times, with bed mobility." The "Interventions" documented in part, "Administer treatments as ordered and monitor for effectiveness. Avoid positioning (Resident #7) on boney areas. (Resident #7) needs reminding/assistance at times to turn/reposition at least every 2 hours, more often as needed or requested, with the use of the ordered 1/2 upper side rails. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Licensed nurses perform a

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weekly skin assessment on her bath day and document any signs of skin breakdown, including skin tears, bruising, maceration, rashes, and reddened areas. NP (nurse practitioner) is notified of any reddened areas- especially if located over a bony prominence. She has a specialized alternating air mattress on her bed to help redistribute potential pressure areas. Insure (sic) it is functioning properly every shift."

There was no documentation in the comprehensive care plan related to an actual pressure area on Resident #7's left heel.

An interview was conducted with LPN #3 on 9/22/16 at 3:02 p.m. LPN #3 was asked if she had notified anyone of the area on the residents heel. LPN #3 stated, "I put it in the doctor communication book." When asked what the treatment was for the wound was on Sunday (9/18/16), LPN #3 stated, "It was the skin tear protocol. The dressing is changed every other day and it was not black before that."

An interview was conducted with administrative staff member (ASM) #2, the director of health services, on 9/23/16 at 8:30 a.m. When asked how often skins assessments are completed, ASM #2 stated, "Non pressure skin assessments are done weekly and pressure ulcer assessments are done weekly also."

An interview was conducted with LPN #1 on 9/23/16 at 8:45 a.m. When asked to describe Resident #7's heels on 8/8/16, LPN #1 stated, "They were soft and boggy." When asked if that is considered a pressure ulcer, LPN #1 stated, "They were not blanching so yes that would be considered a pressure ulcer." When asked if she

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measured the area that was boggy, LPN #1 stated, "No I didn't." LPN #1 then was pulled away to care for a resident.

An interview was conducted with administrative staff member (ASM) #3, the nurse practitioner; on 9/23/16 at 10:06 a.m. ASM #3 was asked who is responsible for assessing and putting treatments in place for wounds. ASM #3 stated, "I am the one who assesses them, measures them and puts treatment in place." When asked if she was certified in wound care, ASM #3 stated, "No, I have the training we received in nurse practitioner school." When asked what reference guidelines she uses to identify wounds, ASM #3 stated, "I have a reference book in the office, a text book that the previous nurse practitioner left for me. She was certified in wound care. I've been here three years so it was hers before she left." When asked to describe a stage 1 pressure ulcer, ASM #3 stated, "The skin is red, warm or cool, no skin breakdown, intact." When asked if boggy heels are considered a pressure ulcer, ASM #1 stated, "Yes, they are." When asked what treatment is put in place for a stage 1 pressure ulcer, ASM #3 stated, "If it's the heels, then we order skin prep and elevate the heels." When asked to describe a stage 2 pressure ulcer, ASM #3 stated, "The breakdown goes through the first layer of skin, it hasn't reached the subcutaneous tissue yet." When asked what treatment should be in place for a stage 2 pressure ulcer, ASM #3 stated, "It depends on if the wound is wet or dry. Elevation of the area involved." When asked if Santyl is used for a stage 2 pressure ulcer, ASM #3 stated, "No usually." When asked to describe Resident #7's left heel wound on 9/19/16, ASM #3 stated, "I called it a stage 2 because it was an unusual color. It was yellow but I didn't believe it was

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slough; it just had a yellow cast to it. I've seen slough once or twice and it didn't look the same." When asked to describe an unstageable wound, ASM #3 stated, "There is slough or eschar tissue that is dying. It may or may not be deep in the tissues." When asked who tracks the wounds at the facility, ASM #3 stated, "The nurses let me know when they see something. I see them once a week unless there is a change."" When asked where she documents the wounds, ASM #3 stated, "In a progress note." When asked how the nurses communicate with her, ASM #3 stated, "Generally I ask them to call the clinic to make an appointment. I try to go on rounds and review the communication book when I can. I check the book every day when I'm on the floor." When asked how often she is on the floor, ASM #3 stated, "On average, I'm on the floor 18-20 times a month, only Mondays through Fridays. There is a doctor on call over the weekend." When asked who's looking at the big picture of wounds in the facility, ASM #3 stated, "I don't know."

An interview was conducted with ASM #2, the director of health services, on 9/23/16 at 10:27 a.m. When asked who is responsible for tracking wounds in the facility, ASM #2 stated, "(ASM #3) should be documenting on the Wound Observation Assessment form. I can't find any. (ASM #3) isn't completing them." When asked which reference guidelines the facility uses for the identification and treatment of pressure ulcers, ASM #2 stated, "The National Pressure Ulcer Advisory Panel." When asked to describe a stage 1 pressure injury, ASM #2 stated, "It's redness, the top layer of skin is not broken, it doesn't blanch." When asked if bogginess is part of a stage 1 pressure area (injury), ASM #2 stated, "Yes." When asked if that area should be

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measured and monitored, ASM #2 stated, "Yes." When asked who is tracking the wounds at the facility, ASM #2 stated, "I was not aware we had any pressure ulcers in the facility. I am the one who is supposed to know that we have them."

An interview was conducted with ASM #2 and ASM #1, the administrator; on 9/23/16 at 11:28 a.m. ASM #1 and ASM #2 were made aware of the concern. ASM #2 presented the physician communication for 8/6/16 that spoke of the "boggy/soft heels." Handwritten on this note was documented, "Yes, skin prep. Float heels." No signature was on this paper. A check off box on the form documented, "Check the box if resident needs to be seen." This box was not checked. The physician communication form dated, 9/11/16, documented, "L heel open, slight drainage, voices much pain when touched. Please evaluate for tx (treatment)." An X was documented in the box to see the resident. Handwritten on the note, ASM #2 explained, they didn't know who wrote the following, "Per NP (nurse practitioner) use skin tear protocol." Neither of these times was the resident examined by the physician or nurse practitioner. The following was reviewed with ASM #1 and ASM #2, that Resident #7 had boggy heels starting on 8/8/16 and there was no measurements obtained, no examination by the NP or MD to stage the boggy heels, no tracking of the boggy heels as a pressure ulcer and including the week before the wound was staged at a stage 2. ASM #2 stated, "You are absolutely correct, we didn't measure it and treat it as a pressure ulcer, we should have."

The facility policy, "Skin Tear Protocol" documented in part, "The standard Skin Tear Protocol will be followed unless contraindicated or

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otherwise directed by the physician. Standing Order: Cleanse any skin tears with warm water, approximate the edges, dress with Mepitel (8), top with dry dressing and secure with roll gauze. Change weekly and earlier if strike through occurs. If Mepitel not available may use adaptic and change every third day."

The facility policy, "Pressure Ulcer Prevention and Care Protocol" documented in part, "Policy: The nurse practitioner or physician must be notified of any pressure ulcer. The nurse practitioner or physician determines and documents treatment protocols for Stage 1 through Stage 4 pressure ulcers and Unstageable and Suspected Deep Tissue Injuries on an individualized basis. If a pressure ulcer is not responding to treatment, alternative treatments are discussed with and ordered by the nurse practitioner and/or attending physician...Documentation: a. Staff nurses to complete the Braden Scale for Predicting Pressure Ulcer Risk on electronic medical record per (Initials of facility) policy on admission, on readmission, quarterly and with a significant change. b. Staff nurses to complete in the electronic medical record Weekly Skin Assessment and Documentation of Preventative Protocols in Place (this is not used to evaluate pressure ulcers) in Health Care only. c. NP will complete Initial Wound/Pressure Ulcer Management sheets for residents with wounds and pressure ulcers and follow-up Pressure Ulcer Reassessment forms for resident with pressure areas per (initials of facility) policy. Pressure Ulcer Staging (Note: only pressure ulcers are staged and the Nurse Practitioner will stage when the initial pressure ulcer evaluation is completed). Stage 1 - Intact skin with non-blanchable redness of a localized area usually over a bony

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prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. Steps should be put into place to develop plans to reduce the risk that more serous pressure ulcer may develop. Stage II (2) -Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation...Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable, (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover' and should not be removed. ...Treatment Documentation: a. nursing staff will ensure dressing is intact as ordered. b. Evaluate effectiveness of treatment plan and confer with NP every week (or more often if necessary) and modify treatment plan as needed; monitor for and report signs of healing, signs of increased involvement and deterioration of area, and signs of infection. c. NP will assess wounds weekly and will document on Wound Management Initial Evaluation and follow-up forms. d. Obtain nurse practitioner's or physician's order for all treatments and treatment changes. e. Document notification of NP in resident record. f. Document treatment administration on the Treatment

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Administration Record. g. NO will document pressure ulcer healing using a Wound Management form and will place the form in the progress notes section of the resident's chart. This will fully explain interventions, assessments, evaluations and referral to dietician. Miscellaneous Medical Management: a. Prevent and manage pressure-ulcer-related pain as needed. Contact nurse manager and the NP immediately of any pressure-ulcer related pain. b. Premedicate with pain medication if needed prior to giving wound care."

Treatment of Pressure Ulcers, U.S. Department of Health and Human Services, Publication Number 15, documents, in part: " The assessment of an individual with a pressure ulcer is the basis for planning treatment, evaluating treatment effects, and communicating with other caregivers. Initially, the clinician should determine the location, stage, and size of the pressure ulcer. Accurate staging and description of pressure sores is a perquisite to the development and implementation of appropriate, effective treatment protocols and to effective, ongoing monitoring of tissue healing." "Use devices that totally relieve pressure on the heels, most commonly by raising the heels off of the bed ...."And also," ....individuals in bed should have a care plan that includes the use of devices that totally relieve pressure on the heels, most commonly by raising the heels off of the bed."

According to Lippincott Manual of Nursing Practice, Eighth Edition, part 2, unit 1, section 9, special health problems of the older adult, page 187, "nursing and patient care considerations in prevention and healing of pressure ulcers; relieve

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the pressure by: reposition every two hours, using special devices to cushion specific areas such as the heels."

No further information was provided prior to exit.

(1) Barron's Medical Guide - Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 523.
(2) Barron's Medical Guide - Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55.
(3) This information was obtained from the following website: <http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/>
(4) This information was taken from the following website: www.npuap.org/resources/educational-and <http://www.npuap.org/resources/educational-and> - clinical - resources/npuap-pressure-injury-stages.
(5) This information was taken from the following website: <https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=19a17354-8ae9-48cf-ad52-cc774ca801be>
(6) This information was taken from the following website: <http://www.rxlist.com/santyl-drug.htm>.
(7) This information was taken from the following website: www.npuap.org/resources/educational-and <http://www.npuap.org/resources/educational-and> - clinical - resources/npuap-pressure-injury-stages.
(8) Mepitel is a soft silicone wound contact layer dressing that minimizes trauma to the wound and pain to the patient during dressing changes.

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Mepitel may remain in place for several days, promoting undisturbed wound healing. The porous structure of Mepitel allows exudate to pass into an outer absorbent secondary dressing. The Safetac layer prevents the outer dressing from sticking to the wound and seals around the wound edges. Mepitel is designed for a wide range of wounds such as skin tears, surgical incisions, second degree burns, and diabetic ulcers. This information was taken from the following website: <http://www.metromedicalonline.com/mepitelall.html>.

(9) The adaptic non adhering dressing is saturated with a specially formulated petrolatum emulsion and knitted out of cellulose acetate fabric to allow exudate to easily pass through to the second absorbent layer. The adaptic dressing is designed to protect the wound while preventing the dressing from getting stuck to the wound. By preventing the fluid to build up at the wound sight the dressing protects regenerating tissue. The dressing can also be cut to the correct wound size without tearing or unraveling. This information was obtained from the following website: <https://www.activeforever.com/johnson-johnson-adaptic-non-adhering-dressing>.

b. The clinical record was reviewed. A nurse practitioner note dated, 8/12/16 at 8:09 a.m. documented, "Staff needed buttocks assessed this week, no pain, no drainage. Skin - right buttocks very small open area 1 cm (centimeters) in diameter, no drainage. I don't think its pressure related, again I feel from shearing. Shearing wound right buttocks - calmoseptine."

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The ingredients in Calmoseptine Ointment: Provide a physical moisture barrier, keeping feces, urine and wound drainage from intact and injured skin. (1)
There was no further documentation of the resident's buttocks in the nurse's notes.

Observation was made of Resident #7's buttocks on 9/23/16 at 8:58 a.m. This surveyor was accompanied by LPN #1. The resident was turned onto her right side. An area was noted on her right buttock. LPN #1 was asked to describe what she observed. LPN #1 stated, "It's a new pressure ulcer. There is some slough; there is a pinhole in the center. It's approximately 1 centimeter in diameter; the skin around it is pink and irritated with bleeding around the edges." When asked if she had seen this before, LPN #1 stated, "No, it's a new finding." The two CNAs (certified nursing assistants) who were in the room had been asked when they last took care of Resident #7, they stated they were helping out today and hadn't taken care of her in over a week or more.
The "Weekly Non Pressure Skin Assessment" dated, 8/14/16, documented, "Skin warm, dry and intact. No new skin issues noted. Preventive measures in place."

The "Weekly Non Pressure Skin Assessment" dated, 8/21/16, documented, "Skin dry and intact, BLE (bilateral lower extremities) edema noted. Placed in MD (medical doctor) book for f/u (follow up)."

The "Weekly Non Pressure Skin Assessment" dated, 8/28/16, documented, "Skin warm, dry and intact. No new skin issues noted. Preventive measures in place."

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The physician orders dated, 2/15/16, documented, "Calmoseptine Ointment; apply to bilateral buttocks topically every shift for Prophylaxis (prevention). May be left in room for staff application. CNA's may apply."

The August eTAR documented, "2/15/16 - Calmoseptine Ointment; apply to bilateral buttocks topically every shift for Prophylaxis (prevention). May be left in room for staff application. CNA's may apply." This was documented as being administered every shift, every day of August.

The "Weekly Non Pressure Skin Assessment" dated, 9/4/16 documented, "Left heel - open area to heel 2 cm x 1.5 cm, dressing in place."

The "Braden Scale for Predicting Pressure Ulcer Sore Risk" dated, 9/16/16, documented Resident #7 was at "high risk" for developing pressure ulcers.

The "Weekly Non Pressure Skin Assessment" dated, 9/18/16, documented, "Left heel - area remain to left heel appox (sic) (approximately) 2 cm (centimeters) x 2.5 cm, slight drainage noted on old bandage. Area cleansed with soap and warm H20 (water) and new dressing applied." There was no sheet completed for the area on Resident #7's right buttock.

There was no "Weekly Non Pressure Skin Assessment" done between 9/4/16 and 9/18/16.

The September eTAR documented, "2/15/16 - Calmoseptine Ointment; apply to bilateral buttocks topically every shift for Prophylaxis

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(prevention). May be left in room for staff application. CNA's may apply." This was documented as being administered every shift, from 9/1/16 through 9/22/16.

An interview was conducted with CNA #1 on 9/23/16 at 9:24 a.m. When asked when she last cared for Resident #7, CNA #1 stated, "I had her on Tuesday (9/27/16). When asked if she had noted anything on her bottom, CNA #1 stated, "It was a little red so I put her on her sides." When asked if she observed any open areas, CNA #1 stated, "No, Ma'am." When asked if she sees a change in the resident's skin what she to do is, CNA #1 stated, "I go to the charge nurse and they take care of it."

An interview was conducted with ASM (administrative staff member) #2, the director of health services, on 9/23/16 at 9:24 a.m. When asked if shearing can be a pressure ulcer, ASM #2 stated, "Yes, it can be." ASM #2 was then shown Resident #7's nurse's note dated 8/12/16. After reviewing the note, ASM #2 stated, "I was not aware of that." When asked if the area documented as "sheer" in the note should have been monitored, ASM #2 stated, "We should have been tracking it even though the nurse practitioner didn't call it a pressure ulcer, shearing can develop into a pressure ulcer." When asked if CNAs are routinely allowed to put on mediation creams, ASM #2 stated, "Yes, we have them do it as they are the ones changing the resident." The observation of the wound on Resident #7's buttock from 9/23/16 was shared with ASM #2. ASM #2 was asked if the area was a pressure sore based on the description of the wound given by LPN #1's during the observation. ASM #2 stated, "Yes, it sounds like one but the nurse

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practitioner is 30 minutes away and she will assess it.

An interview was conducted, over the phone, with administrative staff member (ASM) #3, the nurse practitioner, on 9/23/16 at 10:06 a.m. When asked if she was aware of any skin concerns on Resident #7's buttocks, ASM #3 stated, "No." The nurse practitioner note of 8/12/16 was read to ASM #3. ASM #3 stated, "That was the other nurse practitioner, who was not passed on to me. I am not aware of any concerns with the resident's buttock." The observation of Resident #7's buttocks on 9/23/16 was shared with ASM #3. ASM #3 stated, "I don't know anything about her buttock."

The nurse's note dated, 9/23/16 at 9:36 a.m. documented, "Notified MD of open area to buttocks at this time. Area measuring 0.5 x 0.5 (centimeters), some slough noted to wound bed awaiting new orders. Will continue to turn and reposition and apply Calmoseptine as ordered until otherwise ordered. Resident denies pain to this area. Will continue to observe. POA (power of attorney) had been update on this opening at this time by this nurse."
An interview was conducted with ASM #2, the director of health services, on 9/23/16 at 10:27 a.m. When asked who is responsible for tracking wounds in the facility, ASM #2 stated, "(ASM #3) should be documented on the Wound Observation Assessment form. I can't find any. (ASM #3) isn't completing them." When asked which reference guidelines the facility uses for the identification and treatment of pressure ulcers, ASM #2 stated, "The National Pressure Ulcer Advisory Panel." When asked who is tracking the wounds at the facility, ASM #2 stated, "I was not

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aware we had any pressure ulcers in the facility. I am the one who is supposed to know that we have them."

The nurse practitioner note dated, 9/23/16 at 1:04 p.m. documented, "Assessment of pressure ulcer to R (right) buttock and R (sic) heel completed on wound assessment form."
The "Wound Observation Tool" dated, 9/23/16 documented the following:
Location - R buttock
Indicate whether this site was acquired during the residents stay or whether it was present on admission - acquired.
Date acquired - 9/23/16
Type - pressure
Pressure ulcer stage - Original - Stage 2
Current stage - Stage 2
Overall impression - Epithelial tissue present (pink), moist
Drainage - Serosanguinous
Amount - scant
Odor present - no
Wound measurements - Length - 6 mm (millimeters), width - 4 mm, depth 1 mm.
Peri-wound tissue - intact, dry, no erythema or swelling, well defined edges and smooth.
Signs of infection - no
Inflammation - no
Treatment - frequent turn, off load, Collage cover (foam dressing (2)), Mepitel every 3 days.
Comments - Resident at end of life, activity and food intake have declined significantly, this wound is unavoidable.

An interview was conducted with ASM #1, the administrator and ASM #2; on 9/23/16 at 11:28 a.m. ASM #2 was asked what process the nurses follow if the nurse practitioner is not here. ASM #2

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stated, "They should make a notation of a suspected wound in the communication book." When asked who else looks at that book, ASM #2 stated, "We would call the doctor and ask them to come in." When asked what is done to address the wound until the doctor comes, ASM #2 stated, "We continue to follow nursing standards to turn and reposition, nutrition and hydration. We can do these things without a physician order." When asked if the facility had any pressure ulcer protocols regarding the treatment of pressure ulcers, ASM #2 stated, "No, the nurse practitioner and doctor order the treatment specific to each resident."

ASM #1 and ASM #2 were made aware of the above concern on 9/23/16 at 11:40 a.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website:
www.calmoseptineointment.com
(2) Collagen dressings are meant for wounds with minimal to heavy exudates and also partial- and full-thickness wounds. They stimulate new tissue growth and help to heal necrotic wounds, skin grafts and second-degree burns. Most collagen dressings have antimicrobial agents incorporated to limit spread of infections. Collagen dressings speed up the recovery period due to the growth of new collagen at the wound site. Dressing change frequency varies from daily to every seven days. Available as gels, pastes, powders and freeze-dried sheets and derived from animal sources such as bovine, equine and porcine. This information was obtained from the following website:
http://www.shopwoundcare.com/c-208-collagen-d

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F 329 SS=D 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review it was determined that the facility staff failed to ensure residents were free of unnecessary medications for two of 12 residents in the survey sample, Resident # 2 and #3.

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1. Corrective Action

Resident #2 has an active order to: monitor target behaviors every eight hours; document in the progress notes for the behavior noted, even if none; document all non-pharmacological interventions and outcomes for any noted behaviors and if behaviors escalate or continue to the possibility of self-harm or the possibility of harming others, to immediately notify the MD/NP for further instructions followed by POA notification. Resident # 2's order for Lorazepam (antianxiety medication) was discontinued on 9/24/16. The Haldol order had been discontinued since 7/21/6. Resident #3's order for Alprazolam was discontinued on 10/5/16.

2. Other Potential Residents

All residents prescribed antipsychotic medications are potentially affected. All residents with current orders for PRN psychoactive medications will be reviewed to identify non-pharmacological interventions that will be attempted prior to administration of PRN psychoactive medications with such interventions being documented in the medical record.

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1. The facility staff failed to document non-pharmacological interventions prior to administering Lorazepam (an antianxiety medication (1)) and Haloperidol (an anti-psychotic medication (2)) to Resident #2.

2. The facility staff failed to document non-pharmacological interventions prior to administering Alprazolam (an antianxiety medication (1)) to Resident #3 on four separate occasions in September 2016.

The findings include:

1. Resident #2 was admitted to the facility on 11/12/15 with diagnoses that included, but were not limited to; dementia, Alzheimer ' s, delirium, depression, high blood pressure, hypothyroidism (a low functioning thyroid), anxiety and falls.

Resident #2's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/13/16. Resident #2 was coded as scoring four out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that she was severely impaired with daily decision making.

A review of Resident #2's clinical record revealed a physician order summary report that revealed, in part, the following orders;
"Ativan Tablet 0.5 MG (milligrams) (Lorazepam) Give 0.5 mg by mouth every 12 hours as needed for anxirty (sic). Prescriber written. Order status: Active. Order Date 7/15/16. Start Date; 7/15/16."
"Haloperidol Tablet 2 MG. Give 2 mg by mouth every 6 hours as needed for anxiety. Prescriber written. Order Status Discontinued. Order date:

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7/15/16 Start Date: 7/15/16."

Further review of Resident #2's clinical record revealed a MAR (medication administration record) for July 2016 that revealed, in part, the following medication administrations:
"Ativan Tablet 0.5 MG (Lorazepam) Give 0.5 mg by mouth every 12 hours as needed for anxirty (sic) Start date 7/15/16 1515 (3:15 p.m.)." The medication was documented as administered on 7/17/16 at 1950 (7:50 p.m.) and on 7/26/16 at 1941 (7:41 p.m.).
"Haloperidol Tablet 2 MG. Give 2 mg by mouth every 6 hours as needed for anxiety. Start Date 7/15/16 1515 (3:15 p.m.) D/C (discontinued) date 7/21/16 0735 (7:35 a.m.)" The medication was documented as administered on 7/17/16 at 1555 (3:55 p.m.).

A review of the Nursing Progress notes revealed there was no documentation that non-pharmacological interventions had been attempted on 7/17/16; 7/26/16 and 7/17/17 prior to administering Lorazepam and Haloperidol.

On 9/22/16 at 1:30 p.m. an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked what she did prior to administering Lorazepam or Haldol that was ordered to be administered as needed. RN #2 stated, "I try other methods to calm the resident down prior to administering these medications, as they can be counterproductive. I try to sit down and talk with the resident. I would try non-pharmacological interventions." RN #2 was asked where she would document what she had done prior to administering the medications. RN #2 stated, "I would document in the progress notes."

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On 9/22/16 at approximately 1:45 p.m. an interview was conducted with RN #3, a floor nurse. RN #3 was asked what she would do prior to administering prn Lorazepam or Haldol. RN #3 stated, "I would try to do other things, non-pharmacological interventions." RN #3 was asked whether or not she would document the non-pharmacological interventions, RN #3 stated, "Yes, in the nurses notes."

On 9/22/16 at 2:40 p.m. an interview was conducted with LPN (licensed practical nurse) #5, the unit coordinator. LPN #5 was asked if non-pharmacological interventions should be attempted prior to administering prn Lorazepam or Haloperidol. LPN #5 stated, "Yes, like reposition, toilet or one to one." LPN #5 was asked if this would be documented and why. LPN #5 stated, "Yes it should be documented. This helps support the decision for giving the medication. LPN #5 was shown Resident #2's MAR and asked to provide evidence that non-pharmacological interventions had been done prior to giving Lorazepam and Haloperidol to Resident #2 as a prn treatment in July 2016. LPN #5 stated that there was no documentation to support the administration of prn Lorazepam and Haloperidol.

An end of the day meeting was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing on 9/22/16 at 4:10 p.m. ASM #2 was asked whether or not non-pharmacological interventions should be attempted prior to administering prn Lorazepam or Haloperidol. ASM #2 stated, "Yes and they should be documented in the nurse's notes."

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A review of the facility policy titled, "Psychopharmacological Monitoring" revealed, in part, the following documentation; "Policy: It is the policy of (name of pharmacy) to encourage an interdisciplinary team effort to identify factors that contribute to or are responsible for changes in resident's behavior. The interdisciplinary team recommends approaches to care to assist in the treatment or modification of the resident's behavior, whenever clinically appropriate."

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

(1) A medication used to reduce anxiety, also called Ativan. This information was obtained from the following website: http://www.healthline.com/health/mental-health/lorazepam-vs-xanax
(2) Haloperidol is used to treat nervous, emotional, and mental conditions, also called Haldol. This information was obtained from the following website: http://www.mayoclinic.org/drugs-supplements/haloperidol-oral-route/description/drg-20064173

2. The facility staff failed to document non-pharmacological interventions prior to administering Alprazolam (an antianxiety medication (1)) to Resident #3 on four separate occasions in September 2016.

Resident #3 was admitted to the facility on 9/9/15 with diagnoses that included, but were not limited to; high blood pressure, dementia, depression, cataracts on the eyes, glaucoma (a disease of the

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eyes causing blindness) and hypothyroidism (a low functioning thyroid gland).

Resident # 3's most recent MDS (minimum data set) assessment, was a significant change assessment with an ARD (assessment reference date) of 9/17/16. A BIMs (brief interview of mental status) was not completed in Section C, Cognitve Patterns. A staff assessment was completed in Section C, subsection C0600 and coded Resident #3 as moderately impaired in cognitive skills for daily decision making.

A review of Resident #3's clinical record revealed a MAR dated September 2016 that revealed, in part, the following medication administrations; "Alprazolam Tablet 0.25 mg. Give 0.25 mg by mouth every 12 hours as needed for anxiety. Start Date 7/25/16 0845 (8:45 a.m.). The medication was documented as administered on 9/2/16 at 0751 (7:51 a.m.); 9/3/16 at 0751 (7:51 a.m.); 9/4/16 at 0723 (7:23 a.m.) and 9/5/16 at 1402 (2:02 p.m.).

Further review of Resident #2's clinical record did not reveal any documentation that non-pharmacological interventions had been attempted on 9/2/16; 9/3/16; 9/4/16 and 9/5/16 prior to administering the Alprazolam to Resident #3.

On 9/22/16 at 1:30 p.m. an interview was conducted with RN (registered nurse) #2, a floor nurse, regarding what she does prior to administering alprazolam ordered as prn (as needed). RN #2 stated, "I try other methods to calm the resident down prior to administering these medications, as they can be counterproductive. I try to sit down and talk with

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the resident. I would try non-pharmacological interventions." RN #2 was asked where she would document what she had done prior to administering the medications. RN #2 stated, "I would document in the progress notes."

On 9/22/16 at approximately 1:45 p.m. an interview was conducted with RN #3, a floor nurse. RN #3 was asked what she would do prior to administering alprazolam ordered to be administered as needed. RN #3 stated, "I would try to do other things, non-pharmacological interventions." RN #3 was asked whether or not she would document the non-pharmacological interventions, RN #3 stated, "Yes, in the nurses notes."

On 9/22/16 at 2:40 p.m. an interview was conducted with LPN (licensed practical nurse) #5, the unit coordinator. LPN #5 was asked if non-pharmacological interventions should be attempted prior to administering alprazolam ordered to be administered as needed. LPN #5 stated, "Yes, like reposition, toilet or one to one." LPN #5 was asked if this would be documented and why. LPN #5 stated, "Yes it should be documented. This helps support the decision for giving the medication. LPN #5 was shown Resident 3's MAR and asked to provide evidence that non -pharmacological interventions had been attempted prior to giving prn alprazolam to Resident #3 in September 2016. LPN #5 stated that there was no documentation to support the administration of the prn alprazolam.

An end of the day meeting was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing on 9/22/16 at 4:10 p.m. ASM #2 was asked

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F 329	Continued From page 48 whether or not non-pharmacological interventions should be attempted prior to administering prn alprazolam. ASM #2 stated, "Yes and they should be documented in the nurse's notes." A review of the facility policy titled, "Psychopharmacological Monitoring" revealed, in part, the following documentation; "Policy: It is the policy of (name of pharmacy) to encourage an interdisciplinary team effort to identify factors that contribute to or are responsible for changes in resident's behavior. The interdisciplinary team recommends approaches to care to assist in the treatment or modification of the resident's behavior, whenever clinically appropriate." No further information was made available prior to the end of the survey process. (1) Alprazolam (Xanax) is used to manage anxiety. This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=9294	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F-Tag 371 **1. Corrective Action** The sausage patties, cut meat and brisket were discarded immediately. **2. Other Potential Residents** A walk thru of all other refrigeration and freezer units was conducted on 9/21/16 following the initial inspection. The following day another walk-thru was done on all units to ensure all stored items were properly covered since this has the potential to impact all residents. There were no adverse outcomes reported by residents.	

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F 371	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store food in a sanitary manner in the main kitchen. Food in the freezer and refrigerator were not labeled or covered. The findings included: An observation was made of the main kitchen on 9/21/16 at 10:15 a.m. This surveyor was accompanied by other staff member (OSM) #1, the operations manager. An observation of the freezer, revealed a box of sausage patties, approximately 4 inches in diameter, stored in a bag within a box, with the bag open and the sausage patties exposed to air. In the back of the freezer was a full tray of what appeared to be cut pieces of meat. The wrapping on it was ripped and torn. The meat appeared to have ice crystals on it. There was no label on the container. When asked what was in the tray, OSM #3, a chef manager, could not identify the substance in the pans. He stated the meat had freezer burn. OSM #4, the dietary inventory staff member, was brought in to the freezer. When asked what was in the pan, OSM #4 could not identify the meat. Observation of the refrigerator revealed a half pan of what was labeled "brisket." The plastic was not completely covering the meat and the meat was exposed to air. When asked if it should be covered, OSM #3 stated, "Yes, it should be completely covered." An interview was conducted with OSM #1 and	F 371	**3. Systems Change** Staff responsible and accountable for storing food in any refrigerator/freezer will be retrained on proper food storage techniques and educated on Dining policy & procedures on food storage. Staff responsible to check units on a regular basis will include the Executive Chef, Chef Manager and Sous-Chef. **4. Monitoring** Assigned dining staff in conjunction with the Registered Dietician (RD) and other third party designees will perform weekly food safety audits for the next 60 days. Thereafter, dining staff and the RD will do audits including the normal monthly food safety audit. Results will be reported to the Safety and QAPI Committees. **5. Date** Corrective action will be completed by 11/06/2016.	

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F 371	Continued From page 50 OSM #2, the head chef, on 9/22/16 at approximately 1:20 p.m. The meat that was unidentified was discussed with OSM #1 and OSM #2, OSM #2 stated, "The plastic wrap falls off. If it has no label, we discard it, even if it is the same day." OSM #2 stated the chefs trim meat and they save the pieces to make soup stock. When asked what the meat tray was, OSM #2 stated, "I didn't see it but it could have been lamb chops." OSM #2 was informed that the food on the tray was observed with ice crystals on it and was not labeled. OSM #2 stated, "That's unacceptable." When asked whose responsibility it was to cover the food once opened, OSM #2 stated, "All cooks are to wrap, cover and label all opened foods." The facility policy, "Food Storage" documented, "Procedure: All cooked foods, prepackaged open containers, protein-based salads and desserts are labeled, dated and securely covered." The administrator and director of health services were made aware of the above concern on 9/22/16 at 4:20 p.m.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431	F-Tag 431 **1. Corrective Action** The two bottles of Apisol and the Lorazepam noted were disposed of immediately on 9/23/16 by the DoHS. **2. Other Potential Residents** All residents with liquid or injectable medications have the potential of being affected. All medications in the medication refrigerators were immediately checked for proper dates of use, expirations and shelf life on 9/23/16 by the primary nurse on each respective unit.	

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labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store medications in an appropriate manner in three of three medication rooms.

1. A vial of Aplisol (a sterile aqueous solution of a purified protein fraction for intradermal administration as an aid in the diagnosis of tuberculosis (1)) was dated as opened on 6/28/16 in the Laurel unit medication room.

2. A bottle of Lorazepam (used to treat anxiety

3. Systems Change
Licensed staff will be in-serviced on the medication management, refrigerated medications and their shelf-life and procedures for dating medications after opening. A list of the most frequently refrigerated medications will be obtained from the Pharmacy and posted on the medication refrigerator door in each nurse care base.

4. Monitoring
The DoHS or designee will conduct a monthly medication refrigerator audit for each of the 3 courts for 3 months, then quarterly thereafter. All findings will be reported to the QAPI committee.

5. Date
Corrective action will be completed by 11/06/2016.

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(2)) was not dated when opened, in the Dogwood unit medication room.

3. A bottle of Aplisol was not dated when opened in the Redbud unit medication room.

The findings include:

1. On 9/23/16 at 1:04 p.m. an observation was made of the Laurel unit medication room. A vial of Aplisol was noted in the refrigerator. Handwritten on the vial was an "opened" date of 6/28/16. An interview was conducted with RN (registered nurse) #1, on 9/23/16 at 1:05 p.m. When asked how long a vial of opened Aplisol can be used, RN #1 stated, "I don't know." The package insert was reviewed with RN #1.

The package insert documented, "Storage: Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency."

When asked if the vial should be available for use, RN #1 stated, "No, it should have been discarded."

An interview was conducted with administrative staff member (ASM) #2, the director of health services, on 9/23/16 at 1:15 p.m. When asked how long a vial of Aplisol was good for once opened, ASM #2 stated, "I'd have to look it up it depends on the date of opening." The package insert was reviewed with ASM #2.

ASM #2 provided a copy of the facility policy, "Refrigerated Medications: Storage Instructions and Expiration Dates." The policy documented, "Aplisol - tuberculin PPD - (purified protein

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derivative) - Refrigerate - discard 30 days after opening."

(1) This information was obtained from the following website: http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/ucm114912.pdf

2. An observation was made of the Dogwood unit medication room on 9/23/16 at 1:13 p.m. A bottle of Lorazepam was noted with no date on it when opened. The side of the box the bottle was stored in documented, "Discard after 90 once opened."

An interview was conducted with LPN (licensed practical nurse) #1 on 9/23/16 at 1:13 p.m. When asked how long the bottle of Lorazepam can be used, once opened, LPN #1 stated, "I don't know." The side of the box was shown to LPN #1. When asked if the staff should follow the manufacturer's instructions, LPN #1 stated, "Yes, normally the person who opens the bottle should date it." A copy of the narcotic sheet was requested. The narcotic sheet documented the bottle was received at the facility on 5/19/16 and the first dose was administered on 5/19/16. When asked if there was a system in place to check for expired medications, LPN #1 stated, "Not really. The nurse should have had enough sense to date it when they opened it and I should have checked it too when we counted narcotics at change of shift."

An interview was conducted with administrative staff member (ASM) #2, the director of health services, on 9/23/16 at 1:15 p.m. When asked how long a bottle of Lorazepam was good for once opened, ASM #2 stated, "I would have to

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check, it depends on if it's stored in the refrigerator or if it unrefrigerated. I'll get back with you."

ASM #2 provided a copy of the facility policy, "Refrigerated Medications: Storage Instructions and Expiration Dates." The policy documented, "Lorazepam Intensol - Refrigerate - discard 90 days after opening."

3. An observation was made of the Redbud unit medication room on 9/23/16 at 1:24 p.m. A prescription bottle contained a 1 ml (milliliter) vial of Aplisol. The vial was opened and no date could be found on the vial or the prescription bottle. The prescription label documented it had been sent by the pharmacy on 7/13/16. An interview was conducted with LPN #2 on 9/23/16 at 1:25 p.m. When asked if the opened vial Aplisol was available for use, LPN #2 stated, "We usually don't have that up here. It came from the clinic. It was probably up here for the RNs to give employees their annual TB (tuberculosis) testing." LPN #2 contacted the clinic nurse who gave a date when it was opened. When asked if the vial or prescription bottle should have a date when opened, LPN #2 stated, "Yes, it should be dated."

The administrator was made aware of the above concern on 9/23/16 at 1:30 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/ucm114912.pdf

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F 431	Continued From page 55 (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details	F 431		
F 514 SS=E	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 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate record for three of 12 residents in the survey sample, Resident # 4, #1 and #3. 1. The facility staff failed to file evidence in Resident #4's clinical record that she had consented to and had received an influenza vaccination during the 2015 / 2016 flu season. 2. The facility staff failed to file evidence in Resident #1's clinical record that she had	F 514	F-Tag 514 1. Corrective Action The consent and the administration of the influenza vaccine for Resident #4, #1 and #3 were received from the retail pharmacy that administered the influenza vaccine and placed on the medical record on 9/23/16 prior to surveyors exiting. 2. Other Potential Residents Any resident who received the influenza vaccine 2015-2016 could be affected. 3. Systems Change Following vaccinations, all influenza consents will be cross checked with administration records by either the respective charge nurse or UC and given to the Medical Records Clerk for placement on the medical record. Influenza administration documentation will be part of the EMR (electronic medical record) under the immunization tab. 4. Monitoring The Medical Records Clerk will conduct a weekly audit during the initial immunization schedule, continuing during Flu season each year (August – April), then monthly for the remaining months. Any missing consent documents will be obtained and placed in the medical record. All reports will be submitted to QAPI. 5. Date Corrective action will be completed by 11/06/2016.	

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consented to and had received an influenza vaccination during the 2015 / 2016 flu season.

3. The facility staff failed to file evidence in Resident #3's clinical record that she had consented to and had received an influenza vaccination during the 2015 / 2016 flu season.

The findings include:

1. Resident #4 was admitted to the facility on 9/10/15 with diagnoses that included, but were not limited to: diabetes, arm fracture, anemia (low blood cell count), high blood pressure and dementia.

The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 7/9/16. Resident #4 was coded as scoring 7 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that she was cognitively severely impaired.

A review of Resident #4's electronic clinical record revealed that Resident #4 had received an influenza vaccination on 10/9/15. There was no evidence of the consent for the influenza vaccination in Resident #4's physical clinical record.

On 9/22/16 at 12:30 p.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked where the evidence of influenza vaccinations along with the consent and verification of education was kept. ASM #2 stated that there was an entry in the electronic clinical record that indicated the manufacturer

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and lot number of the vaccination given and the originals were kept in the residents' paper chart. ASM #2 was asked to supply evidence that the influenza vaccination along with the consent and proof of education were given to Resident #4.

On 9/22/16 at 4:10 p.m. during an end of day meeting, ASM #2 provided the copies of administration, consent and education for the influenza vaccination administered to Resident #4 in 2015. ASM #2 was asked where she had obtained the paperwork, ASM #2 stated, "It was at the local pharmacy, they did the vaccinations this year so the records were in their files. ASM #2 was asked whether or not the paperwork should be kept in the resident's clinical record, ASM #2 stated that it should but it was not there. ASM #1, the administrator was in attendance during the end of day meeting.

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

2. The facility staff failed to file evidence in Resident #1's clinical record that she had consented to and had received an influenza vaccination during the 2015 / 2016 flu season.

Resident #1 was admitted to the facility on 10/8/15 with diagnoses that included, but were not limited to: heart disease, dementia, high blood pressure, glaucoma (a disease of the eyes causing blindness), failure to thrive, and depression.

Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/13/16, coded Resident #1 as scoring 10 out of a possible 15 on

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the BIMs (brief interview for mental status), indicating Resident #1 was moderately impaired with daily decision making.

A review of Resident #1's electronic clinical record revealed that Resident #1 had received an influenza vaccination on 9/17/15. There was no evidence of the consent for the influenza vaccination in Resident #1's physical clinical record.

On 9/22/16 at 12:30 p.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked where the evidence of influenza vaccinations along with the consent and verification of education was kept. ASM #2 stated that there was an entry in the electronic clinical record that indicated the manufacturer and lot number of the vaccination given and the originals were kept in the residents' paper chart. ASM #2 was asked to supply evidence that the influenza vaccination along with the consent and proof of education were given to Resident #1.

On 9/22/16 at 4:10 p.m. during an end of day meeting, ASM #2 provided the copies of administration, consent and education for the influenza vaccination administered to Resident #1 in 2015. ASM #2 was asked where she had obtained the paperwork, ASM #2 stated, "It was at the local pharmacy, they did the vaccinations this year so the records were in their files. ASM #2 was asked whether or not the paperwork should be kept in the resident's clinical record, ASM #2 stated that it should but it was not there. ASM #1, the administrator was in attendance during the end of day meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VLY WESTMINSTER-CANTERBURY	300 WESTMINSTER CANTERBURY DR WINCHESTER, VA 22603

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F 514	Continued From page 59	F 514		

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

3. The facility staff failed to file evidence in Resident #3's clinical record that she had consented to and had received an influenza vaccination during the 2015 / 2016 flu season.

Resident #3 was admitted to the facility on 9/9/15 with diagnoses that included, but were not limited to; high blood pressure, dementia, depression, cataracts on the eyes, glaucoma (a disease of the eyes causing blindness) and hypothyroidism (a low functioning thyroid gland).

Resident # 3's most recent MDS (minimum data set) assessment, was a significant change assessment with an ARD (assessment reference date) of 9/17/16. In Section C, Cognitive Patterns, C0100 through C0500, contained dashes for each section. A staff assessment was completed in Section C0600 coding Resident #3 as moderately impaired in cognitive skills for daily decision making.

A review of Resident #3's electronic clinical record revealed that Resident #3 had received an influenza vaccination on 9/16/15. There was no evidence of the consent for the influenza vaccination in Resident #3's physical clinical record.

On 9/22/16 at 12:30 p.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked where the evidence of influenza vaccinations along with the consent and verification of education was kept. ASM #2

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stated that there was an entry in the electronic clinical record that indicated the manufacturer and lot number of the vaccination given and the originals were kept in the residents' paper chart. ASM #2 was asked to supply evidence that the influenza vaccination along with the consent and proof of education were given to Resident #3.

On 9/22/16 at 4:10 p.m. during an end of day meeting, ASM #2 provided the copies of administration, consent and education for the influenza vaccination administered to Resident #3 in 2015. ASM #2 was asked where she had obtained the paperwork, ASM #2 stated, "It was at the local pharmacy, they did the vaccinations this year so the records were in their files. ASM #2 was asked whether or not the paperwork should be kept in the resident's clinical record, ASM #2 stated that it should but it was not there. ASM #1, the administrator was in attendance during the end of day meeting.

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

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F 000	Initial Comments	F 000		

An unannounced biennial State Licensure survey was conducted 9/21/16 through 9/23/16 Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.

The census in this 40 certified bed facility was 38 at the time of the survey. The survey sample consisted of 11 current resident reviews (Residents 1 through 9, #11 and #12) and 1 closed record reviews (Residents #10).

F 001 Non Compliance

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

This RULE: is not met as evidenced by:
12VAC5-371-140. Policies and procedures

Based on staff interview and facility document review, it was determined that the facility staff failed to obtain nursing license verification for two of 25 state employee record reviews.

The facility staff failed to access the state department of health professions website to obtain nursing license verification for LPN (license practical nurse) #1 and RN (registered nurse) #1.

The findings include:

LPN #1 was hired on 9/3/15. RN #1 was hired on 9/8/16. Review of LPN #1 and RN #1's employee records failed to reveal evidence the state department of health professions website was accessed to verify the nurses held current valid nursing licenses in the state of Virginia. Copies of the nurses' licenses were in the employee records

F 001

F-Tag 001

1. Corrective Action

LPN #1 was hired on 9/3/15. This LPN was initially licensed on 8/26/15, less than a week prior to their hire date. RN #2 was hired on 9/8/16. License Lookup was reviewed by the Human Resources Coordinator and a copy of the results placed in both employees personnel file.

2. Other Potential Residents

HR staff will review personnel files by October 28, 2016 for all licensed staff hired since August 2016 to verify the files contain the License Lookup verification form.

3. Systems Change

We have changed the timing of the License Verification process to now occur when the application is initially received and before it is forwarded to the hiring manager for review and consideration. The HR Coordinator will not forward any license that is in good standing for consideration.

4. Monitoring

A designated HR staff member, not involved in the direct hiring process will audit all licensed new hires on a monthly basis with findings submitted to the QAPI committee.

5. Date

Corrective action will be completed by 11/06/2016.

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

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F 001	Continued From Page 1	F 001		

but the copies were not dated and failed to document if any additional public information was available. Also, there was no verification the licenses were active at the time of hire.

On 9/22/16 at 3:24 p.m., an interview was conducted with OSM (other staff member) #1 (the human resources coordinator). OSM #1 was asked the process for nursing license verification for newly hired nursing employees. OSM #1 stated, "Usually we ask them to bring a copy of their license and go to the department of nursing website." OSM #1 stated she tries to complete license verification before nursing employees are hired. OSM #1 stated she keeps a copy of the license and a copy of the license verification from the website in the employee files. At this time, OSM #1 was asked to provide license verification for LPN #1 and RN #1.

On 9/22/16 at 3:29 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings.

On 9/22/16 at 3:36 p.m., OSM #1 provided copies of LPN #1 and RN #1's licenses but could not provide evidence that their licenses were verified through the department of health profession's website. OSM #1 stated she generally verifies all nurses' licenses through the department of health profession's website. OSM #1 stated she didn't know if she forgot to do so or misfiled the verifications.

On 9/22/16 at 4:56 p.m., ASM #1 was made aware of the additional findings.

The facility policy titled, "Abuse, Resident" documented in part, "4. To protect our residents and to prevent incidents of abuse, neglect, and exploitation personnel screening and selection

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F 001	Continued From Page 2	F 001		

policies will be in place to help ensure that residents will not be subjected to abuse (verbal, sexual, physical, mental), involuntary seclusion, mistreatment, neglect, and misappropriation of property. These policies include: a. the verifying of professional licenses with the appropriate licensing bodies..."

No further information was presented prior to exit.

12 VAC 5 - 371 - 250 F cross references to Federal deficiency 278, 280

12 VAC 5 - 371 - 220 B cross references to Federal deficiency 309

12 VAC 5 - 371 - 220 C.1. cross references to Federal deficiency 314

12 VAC 5 - 371 - 340 cross references to Federal deficiency 371

12 VAC 5 - 371 - 300 B cross references to Federal deficiency 431
12VAC5-371-360 Clinical Records - cross reference to - F514

12VAC5-371-220 Nursing Services - cross reference to - F329