| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| SIGNATURE HEALTHCARE OF NORFOLK | 1005 HAMPTON BLVD NORFOLK, VA 23507 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 1/12/16 through 1/14/16. Five complaints were investigated during the survey. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements.<br><br>The Life Safety Code survey/report will follow.<br><br>The census in this 169 certified bed facility was 141 at the time of the survey. The survey sample consisted of 25 resident reviews; 22 current residents (Residents #1 through #21 and #25) and 3 closed record reviews (Residents #22 through #24). | F 000 | Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law. | |
| F 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident | F 157 | Resident # 22 has been discharged.<br><br>Admissions director to review residents at the center that may have the potential for this deficiency. The responsible party and emergency information are updated as indicated on the face sheet. | |

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

Administrator 2-9-16

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

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| F 157 | Continued From page 1<br>and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a complaint investigation, medical record review, family interviews and staff interviews the facility staff failed to promptly notify a resident's emergency contact regarding a significant medication error for 1 of 25 residents in the survey sample, Resident #22.<br><br>The facility staff failed to notify Resident #22's emergency contact promptly on 5/31/15 when a significant medication error was discovered with the resident's medication Onfi.<br><br>The findings included:<br><br>Resident #22 was a 54 year old originally admitted to the facility on 2/9/15 and then readmitted on 5/11/15. Resident #22's admitting diagnoses include *Seizures, *Epilepsy and *Depression.<br><br>*Seizures: a hyperexcitation of neurons in the brain leading to abnormal electric activity that causes a sudden, violent involuntary series of contractions of a group of muscles. | F 157 | SDC to In-service the nursing staff on resident's rights on change in conditions and documentation completed on 2/9/16- 2/10/16.<br><br>Changes of conditions are being reviewed by Unit Managers during clinical meeting. This process started on 2/2/16. During the meeting the DON/designee will verify documentation entered in the resident's charts and notifications to appropriate parties have been completed.<br><br>The audits results and any findings will be presented at the QAPI meeting monthly until sustainability is attained.<br><br>RECEIVED<br>FEB 10 2016<br>VDH/OLC<br><br>Date Certain: 2/14/16 | |

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| F 157 | Continued From page 2<br><br>*Epilepsy: a group of neurologic disorders characterized by recurrent episodes of convulsive seizures, sensory disturbances, abnormal behaviors, loss of consciousness, or all of these.<br><br>*Depression: a decrease of vital functional activity, a mood disturbance characterized by feelings of sadness, despair, and discouragement resulting from and normally proportionate to some personal loss or tragedy.<br><br>The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.<br><br>The most recent Minimum Data Set (MDS) assessment was an Admission 5 day assessment with an Assessment Reference Date (ARD) of 5/18/15 with a Brief Interview for Mental Status (BIMS) pf a 7 out of a possible 15 which indicated that the resident was moderately cognitively impaired and require assistance with daily decision making.<br><br>Resident #22's Admission Record Face Sheet under Emergency Contact listed his sister with working phone numbers.<br><br>A review of Resident #22's medical record revealed a neurological consult on 5/18/15 with the following new order: Onfi 5 mg (milligrams) bid (twice a day).<br><br>*Onfi: is a a benzodiazepine. Onfi affects chemicals in the brain that may become unbalanced and cause anxiety. Onfi is used in combination with other medications to treat seizures associated with epilepsy. | F 157 | | |

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| F 157 | Continued From page 3<br><br>The above definitions were derived from facility's pharmacy drug sheets: www.drugs.com.<br><br>Physician order dated 5/18/15 documented in part, read as follows:<br>2. Onfi 5 mg via (by) Peg (feeding tube) Bid (twice a day).<br><br>Resident #22's Medication Administration Record for May 19th through the 30th of 2015 indicated the following physician order for Onfi: ONFI GIVE 5 ML VIA (by) PEG (feeding tube) TWICE DAILY SEIZURE DISORDER. Nurse's signatures indicating that this medication was administered as transcribed on the Medication Administration were visualized for the above dates.<br><br>A timeline written by the Director of Nursing regarding Resident #22 was presented to this surveyor. The timeline was reviewed and documented in part, read as follows:<br><br>On 5/31/2015 the day shift notice that the ONFI was transcribe with the wrong dose. The error was 5 ml (milliliter) BID (twice a day) instead of 5 mg (milligram) (2 ml). Dr. (name) was notify immediately and orders received to hold 9 a.m. and 9 p.m. dose for today. On 6/1/15 begin ONFI 5 mg (2 ml) BID. Mrs. (name, resident's sister) was notify of the error.<br><br>On 1/13/16 at 5:15 p.m. an interview was conducted via telephone with Resident #22's sister. During the interview the sister stated, "I was never called and made aware that my brother has been been give double the amount of his ONFI. I understand that errors can happen, but I'm supposed to be called and no one had | F 157 | | |

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| F 157 | Continued From page 4<br>called to tell me."<br><br>On 1/14/15 at 7 p.m. the Director of Nursing stated, "I can't find the documentation where we called the resident's sister about the medication error, but I can get the nurse on the phone and she can tell you she called." Surveyor stated, "without dated and timed documentation that the sister was called at the time the medication error was noted, there is no proof that she was notified."<br><br>A review of Resident #22's Medication Administration Record for May 31, 2015 indicated the following order: ONFI 2.5 MG/ML, GIVE 2 ML VIA PEG 9 AM AND 9 PM START 6/1/2015.<br><br>Physician order dated 5/31/15 documented in part, read as follows:<br><br>1. Hold ONFI (clobazam) today.<br>2. Begin same dose on 6/1/15 (Monday).<br><br>Nurse's Note on 5/31/15 for the 3-11 shift documented in part, read as follows:<br><br>Dr. (name) notified of ONFI administration order: Hold onfi today. Begin same dose 2 ml at 9 am and PM and labs to be drawn.<br><br>Nurse's Note on 6/1/15 for the 7-3 shift documented in part, read as follows:<br><br>Pt. (patient) is day 2/3 med. (medication) error with no adverse reactions noted this shift. Medicine onfi held 5/31 and to restart 6/1/15.<br><br>Resident #22's Controlled Drug Record dated 5/21/15 through 6/2/15 for the medication ONFI | F 157 | | |

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| F 157 | Continued From page 5<br>2.5 MG/ML Suspension was reviewed. On the pharmacy label the following instructions were written and hi-lighted in yellow for administration: 2 ML (5 MG) BY MOUTH IN THE MORNING AND 2 ML (5 MG) BY MOUTH IN EVENING**NO REFILL**. Based on the Controlled Drug Record Resident #22 received 16 doses of ONFI 5 ml instead of the physician ordered 2 ml. Based on the physician order for ONFI Resident #22 was to receive 5 mg twice a day, however with the 16 doses that were given at 5 ml the resident received over 10 mg of ONFI per dose given.<br><br>The Director of Nursing provided facility Coaching and Counseling Session documentation dated 6/4/15 which documented in part, read as follows:<br><br>Please describe the Stakeholder's conduct and indicate the specific policy that has been violated.<br><br>Careless mistake that affect the safety of a resident: stakeholder failed to practice proper procedure in carry out of MD (medical doctor) order. Telephone order written on 5/18/15=ONFI 5 mg via peg. tube bid- you transcribed on EZ mar (electronic medication administration record) ONFI 5 ml bid.<br><br>The Coaching and Counseling Session documentation was signed by the Registered Nurse who had made the transcription error.<br><br>The Director of Nursing provided documentation indicating inservice training on Transcribing Physician Orders, Chart Audits, Medication Administration Audits, and Documentation for the month of June 2015.<br><br>The Facility Policy titled "Medication | F 157 | | |

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| F 157 | Continued From page 6<br>Discrepancies" dated 6/1/15 documented in part, read as follows:<br><br>Medication Discrepancies are documented and reported to the resident's attending physician, DON (Director of Nursing), responsible party and the Performance Improvement Committee. In addition to reporting discrepancies that result in the patient receiving an incorrect medication, medication discrepancies that have the potential for but do not actually result in the patient receiving an incorrect medication are documented and reported.<br><br>The Facility Policy titled "Change of Condition" dated 6/25/15 documented in part, read as follows:<br><br>6. Notify the resident's responsible party of a change and follow through completed by the facility, and documented in the medical record.<br><br>On 1/14/15 at 5:30 p.m. during a pre-exit interview with the Administrator and the Director of Nursing the above findings were shared. The Director of Nursing stated, "There was a transcription error and the wrong dose was given for a few days. I did inservicing with the nursing staff." No further facility information was provided.<br><br>This is a COMPLAINT DEFICIENCY. | F 157 | | |
| F 167 SS=C | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE<br><br>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of | F 167 | The facility immediately placed the survey book in a place readily accessible to residents and posted a notice of their availability on 1/14/16. | |

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| F 167 | Continued From page 7<br>correction in effect with respect to the facility.<br><br>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and group interview, the facility staff failed to have past survey results available to Residents and the general public without having to ask.<br><br>The findings include:<br><br>During general observations of the facility, conducted 1/12/16 through 1/14/16, a plastic holder was observed sitting on the counter at the reception window that indicated the survey results were kept with the receptionist. When this writer asked how residents were able to read the report of the last survey results, the receptionist said, "If they ask me to see them, I will get the book and let them read it." This location required a verbal request by a resident or other interested party in order to view the results.<br><br>During a Group Interview, conducted on 1/13/16 at 1:30 p.m. with 5 cognizant and interviewable residents, the group was not aware of the location of the State survey results. When asked, one Resident stated, "I do not know where that is". The consensus of the group was that they were not aware of the results or where they were located. | F 167 | Resident council meeting called to discuss resident rights and location of survey book. Completed 2/8/16<br><br>The CEO/designee will audit the book location 3 times a week for one month and then 1 time a week for 3 months. | 2/14/16 |

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| F 167 | Continued From page 8<br>During random anonymous Resident interviews, none of the Residents were aware of where the survey results were located.<br><br>On 1/14/16 at 3:00 p.m., the Administrator stated the reason why the survey book with the recent survey results were kept with the receptionist was because the staff said the survey book kept disappearing. He stated, "I can come up with another plan." | F 167 | | |
| F 274 SS=D | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, staff interviews and review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) manual the facility staff failed to complete a significant change assessment for 1 of 25 residents, (Residents #11), in the survey sample. | F 274 | Resident #11 MDS assessment for significant change was completed on 1/29/16.<br><br>MDSC will review entered residents data prior to closing and submission. MDSC/Designee to check for flags on the assessments for changes in condition.<br><br>MDSC/Designee will review current MDS calendar for any resident that were readmitted after hospitalization with IDT members to determine if significant change criteria was met per RAI guidelines.<br><br>The scheduled residents' assessments to be discussed with IDT members to determine if significant change criteria was met per RAI guideline. MDSC/Designee to audit 1 time a week for 4 weeks, and then once a month for three months. | |

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| F 274 | Continued From page 9<br>Facility staff failed to complete a significant change Minimum Data Set (MDS) assessment for Resident #11 after staff recognized he had experienced major declines in 2 or more areas.<br><br>The findings included:<br><br>Resident #11 was originally admitted to the facility 4/1/15 and has not been discharged from the facility since this admission. The current diagnoses are vascular dementia, hypertension, peripheral vascular disease, schizophrenia, an anxiety disorder, benign prostate hypertrophy, a seizure disorder, glaucoma, and a vitamin D deficiency.<br><br>Resident #11 admission MDS assessment with an assessment reference date (ARD) of 4/8/15 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scored 1 out of 15. Resident #11 was unable to complete the BIMS for the 12/31/15 quarterly MDS assessment therefore staff information was entered.<br><br>The 4/8/15 Admission MDS assessment coded Resident #11 in section "G" (Physical Functioning) as requiring supervision after setup with transfers, oversight only after setup with in room ambulation, supervision only after setup with ambulation in the corridor and oversight after setup with eating.<br><br>The 12/31/15 quarterly MDS assessment coded Resident #11 in section "G" (Physical Functioning) as currently requiring extensive assistance of 1 with transfers, in room ambulation and eating. It also revealed Resident #11 is only walked in the corridor once or twice during the | F 274 | The audit results and any findings will be presented at the QAPI meeting monthly until sustainability is attained.<br><br>Date Certain: 2/14/16 | |

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| F 274 | Continued From page 10<br>observation period and with staff assistance.<br><br>The above information reveals the Resident #11 had declined in cognition, the ability to transfer, walk and to self-feed.<br><br>On 1/13/16 at 11:20 a.m. Resident #11 was observed sitting up in bed calling for assistance to the bathroom. A staff member entered, put his shoes on and assisted him into the bathroom.<br><br>On 1/14/16 at approximately 5:20 p.m. the MDS Coordinator was asked for a copy of the facility's policy on completion of MDS assessments. The MDS Coordinator stated there is no facility policy for the completion of the MDS assessments. The facility staff follows the instructions as outlined in the MDS 3.0 RAI manual.<br><br>The MDS 3.0 RAI manual states a significant change is a decline or improvement in the resident's status:<br><br>1. Will not normally resolve itself without interventions from the staff or by implementing standard disease-related clinical interventions, is not "self-limiting" (for declines only);<br><br>2. Impacts more than one area of the resident's health status; and<br><br>3. Requires interdisciplinary review; and/or revision of the care plan (MDS 3.0 RAI user's manual, Chapter 2 page 2-20, April 2015)<br><br>On 1/14/16 at approximately 5:40 p.m. the MDS Coordinator stated she would speak to other staff regarding Resident #11 status. Upon the MDS Coordinator's return she stated staff agreed | F 274 | | |

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| F 274 | Continued From page 11<br>Resident #11 had experienced a significant change as indicated by his increased dependence on the staff for daily care. The MDS coordinator stated the 12/31/15 MDS assessment would be modified to reflect a significant change assessment.<br><br>On 1/14/16 at approximately 6:10 p.m. the above findings were shared with the Administrator, Director of Nursing and the Corporate Care Consultant. The Director of Nursing stated Resident #11 now requires more assistance and all necessary care as identified in the plan of care was being rendered. | F 274 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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.<br><br>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 | Resident #3 care plan has been reviewed and revised by IDT members on 1/15/16.<br><br>All residents at the center have the potential for this deficiency. MDS coordinator reviewed all care plans on the current MDS calendar to assure current care plans are revised (1/19/16).<br><br>MDS coordinator or designee to audit scheduled OBRA related assessment and assure current care plan is revised and reflects resident status for 3 months and then quarterly. | |

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| F 280 | Continued From page 12<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, staff interviews and facility documentation, the facility staff failed to revise the care plan for 1 of 25 (Resident #3) in the survey sample.<br><br>For Resident #3, the facility staff failed to revise and individualize the Care Plan to reflect changes in Resident #3's problems of the following areas: sacral decubitus ulcer, dental problems, self care deficits, recreational interests/patterns, risks for complications related to elimination patterns, and behaviors.<br><br>The findings include:<br><br>Resident #3 was admitted to the facility on 04/18/14 with a readmission on 01/12/16. Diagnoses for Resident #3 included but are not limited to: Paraplegia (paralysis-loss of muscle function of lower extremities), Stage III sacral decubitus ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org), Diabetes Mellitus (disease where the body's blood sugars are high), Depressive Disorder (serious medical condition that involves the brain) , anxiety, psychosis (a severe mental condition that causes abnormal thinking and perceptions), ileostomy (bottom of the small intestine (ileum) is attached to a stoma and exits the abdomen where stool is collected in a bag, colostomy (the colon is attached to the stoma and exits the abdomen where stool is | F 280 | The audit results and any findings will be presented at the monthly QAPI meeting until sustainability is attained.<br><br>Date Certain: 2/14/16 | |

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| F 280 | Continued From page 13<br>collected in a bag), gun shot injury and bilateral (both sides) lower extremity amputations.<br><br>Resident #3's annual MDS (Minimum Data Set - an assessment protocol) with an ARD (assessment reference date) of 10/10/15 assessed Resident #3 as requiring extensive assistance with one staff member assistance for Dressing and Toileting. Resident #3 was assessed as requiring extensive assistance with two staff person assistance for Bed Transfers and Hygiene. Resident #3 empties urine from a tube inserted into the bladder from the abdomen (supra-pubic) catheter. Resident #3 empties bowels through a colostomy and ileostomy.<br><br>Resident #3's careplan problem of Pressure Ulcers initiated on 08/19/14 noted absence of dates for the following: changes of wound care orders, sacrum stage III resolution.<br><br>Resident #3's careplan problem of Pressure Ulcer initiated on 12/14/15 did not indicate current wound care or changes related to wound care treatments.<br><br>Resident #3's careplan problem of Pressure Ulcer initiated on 12/14/15 did not date the second reopening of the pressure ulcer and did not specify wound care treatments.<br><br>Resident #3's careplan problem of Dental problems initiated on 12/21/15 noted no updates from dental evaluation nor date of dental evaluation.<br><br>Resident #3's careplan problem of Self Care Deficit initiated 10/14/15 indicated no specific reasons for the problem such as bilateral | F 280 | | |

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| F 280 | Continued From page 14<br>amputation. The goals and approaches were noted to be all general and not individualized for Resident #3.<br><br>Resident #3's careplan problem of Resident has previous recreational interests/patterns initiated 10/14/15 does not indicate Resident's interests or activity desires. Approaches are all very generalized and are not individualized for Resident #3. There is no mention to this area of a barrier of not attending activities as his broken wheelchair reported by Resident #3 to be in Physical Therapy for repairs.<br><br>Resident #3's careplan problem of risk for complications related to altered elimination device for bowel and or bladder elimination is not individualized for Resident #3 as it does not list his suprapubic catheter, ileostomy or colostomy. The Careplan doesn't specify the location of the ileostomy versus the colostomy. There are no updates to this problem since initiation.<br><br>Resident #3's careplan problem of at risk and active behavior problem initiated 09/08/15 listed in approaches: to reduce the following stressors that may be contributing to the resident's inappropriate behavior: and has a blank to be filled in with behaviors that has no documentation in the blank. There are no updates noted to the careplan problem since it's initiation.<br><br>Review of document provided by the Director of Nursing (DON) related to careplans entitled: "CMS's (Center Medicaid Service) RAI (Resident Assessment Instrument) Version 3.0 Manual Chapter 4 CAA (Care Area Assessment) Process and Care Planning" with a date of October 2015 noted the following: | F 280 | | |

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| F 280 | Continued From page 15<br><br>A well developed and executed assessment and care plan: looks at each resident as a whole human being with unique characteristics and strengths.<br><br>Re-evaluates the resident's status at prescribed intervals...or if a significant change in status occurs...<br><br>Evaluating treatment of measurable objectives, timetables and outcomes of care.<br><br>An interview was conducted with Unit 2 Unit Manager Employee # RN 1 on 01/13/16 at approximately 12:30 p.m. RN (registered nurse) #1 stated: "I think the MDS person made a mistake with the careplan" in a response to request for clarification of the careplan update for pressure ulcer care. When RN #1 was asked if she felt Resident #3 was considered incontinent with a suprapubic tube, ileostomy, and colostomy, she stated: "no, but he was having drainage from the rectum." When asked if this drainage or the ostomies were specified on the careplan, RN #1 responded: "No." RN #1 was asked when the floor nurses update a careplan, she stated: "Floor nurses will update careplan for a new behavior or antibiotic. Otherwise MDS does it."<br><br>An interview was conducted with the wound care nurse #2 on 01/13/16 at approximately 1:40 p.m. When asked if she felt the pressure ulcer careplan clearly updated all the changes and actions done by nursing related to the pressure ulcers. She stated: "No... all not documented as we are so busy there's not time to write it all." When asked if she felt the careplan was clear to follow for someone who doesn't know Resident | F 280 | | |

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| F 280 | Continued From page 16<br>#3, she stated: "No it is not clear to follow change."<br><br>An interview was conducted with the DON (Director of Nursing) on 01/13/16 at approximately 3:40 p.m. When asked what the expectations were as to who and when careplanning can be documented, DON #2 stated: "It is my expectation that any nurse caring for the resident can update the careplan with any incident or any problems with the patient." The DON #2 agreed that Resident #3's careplan is not individualized and updated."<br><br>The Facility Administration including the Administrator #1, DON #2, and Corporate Care Consultant #1 was informed of the findings during a briefing on 01/14/16 at approximately 6:15 p.m. No further information was provided. | F 280 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, clinical record review, staff and resident interview and facility documentation, the facility staff failed to ensure care was provided to maintain the highest practicable physical well-being for 4 of 25 | F 309 | Resident #1, #2, and #3, care plans and pain management orders revised to include non-pharmaceutical Interventions on 1/18/16.<br>Resident #22 has been discharged | |

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| F 309 | Continued From page 17<br>residents (Resident #1, #2, #3 and #22) in the survey sample.<br><br>The facility staff failed to offer non-pharmacological approaches prior to offering pain medications for Resident #1, #2, and #3.<br><br>The facility staff failed to ensure that the physician orders for the medication Depakote were transcribed and followed for Resident #22.<br><br>The findings include:<br><br>1. Resident #1 was admitted to the nursing facility on 11/12/14 with diagnoses that included anoxic brain damage, heart transplant recipient, anxiety, leg fractures, depression and gastroesophageal reflux disease (GERD).<br><br>The Minimum Data Set (MDS) assessment dated 11/10/15 was an Annual and coded Resident #1 with a score of 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact in the skills for daily decision making. In the pain section of the MDS, it was coded the staff conducted a pain assessment and that the resident was offered and/or received as needed (PRN) pain medication. It was assessed that the resident did not receive any non-medication interventions for pain.<br><br>The care plan dated 11/12/15 identified the resident had an alteration in comfort/pain. The goal was that the resident's pain would be controlled to a satisfactory level. Some of the approaches the staff would use to accomplish this goal included observe for pain and intervene | F 309 | Residents' physician's orders and care plans have the potential for this deficiency. MDSC or designee will conduct care plans audits to review and revise as indicated.<br><br>Unit Managers will audit the resident's physician order sheets to include non-pharmaceutical interventions for pain. The unit Managers will conduct Physician orders audits to electronic medication administration records for transcription accuracy.<br><br>Residents evaluated for pain management will be offered non-pharmaceutical interventions.The SDC in-serviced nursing staff on following Physician orders procedures and non-pharmaceutical interventions for pain. DON/designee will review new physician's orders in the morning clinical meeting. Unit Managers will audit residents' new orders charts for compliance three times a week for one month, then weekly for three months.<br><br>The audits results and any findings will be presented at the QAPI meeting monthly until sustainability is attained.<br><br>Date Certain: 2/14/16 | |

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| F 309 | Continued From page 18<br>as needed, position to decrease pain, attempt non-medical interventions as needed and administer medications as ordered.<br><br>Resident #1 had the following physician orders for PRN pain medication:<br>-1/28/15 for *Hydrocodone 5-325 milligrams (mg), 1 tablet by mouth every 4 hours PRN for pain.<br>-1/5/15 for *Oxycodone 5-325 mg, 1 tablet by mouth every 4 hours PRN for pain.<br><br>*Hydrocodone is a controlled substance class II narcotic pain reliever with a high potential for abuse. The lower the schedule, the higher potential for abuse (www.drugs.com/schedule-2-drugs.html).<br><br>*Oxycodone is an opioid pain medication. An opioid is sometimes called a narcotic. Oxycodone is used to treat moderate to severe pain. The extended-release form of this medicine is for around-the-clock treatment of pain. It is a controlled substance class II narcotic pain reliever with a high potential for abuse. The lower the schedule, the higher potential for abuse (www.drugs.com/schedule-2-drugs.html)<br><br>Review of the clinical record revealed Resident #1 received narcotic pain medication 34 times over the last 3 months (November 2015, December 2015 to current review date of 1/14/16) with no supporting documentation to indicate non-pharmacological measures were implemented prior to administering medication.<br><br>An interview was conducted with Resident #1 on 1/14/16 at 11:30 a.m., at which time she stated | F 309 | | |

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| F 309 | Continued From page 19<br>she sometimes asked for pain medication because she was stiff and had bilateral leg pain, but at other times the nurse's would ask her and she would accept the medication or they just bring it without her asking the nurses. She stated, "They don't do anything other than give me pain medication."<br><br>On 1/14/16 at 9:55 a.m., an interview was conducted with the medication administration nurse, LPN #8. She stated, "We cannot show you that other things are done when a resident has pain, but I am sure we try to make residents comfortable. When a resident asked for pain medication or if we think they are in pain, we administer it."<br><br>On 1/14/16 at 5:45 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated she did expect the staff to try other measures prior to giving PRN pain medication, but she did not have an avenue by which the nurses could document what they do prior to giving PRN pain medication and she doubted if there was documentation in the nurses notes to support offering and trying non-pharmacological interventions prior to giving medication.<br><br>2. Resident #2 was admitted to the nursing facility on 1/17/14 with diagnoses that included chronic pain, psychosis, diabetes, muscle weakness, muscle disuse and anemia.<br><br>The most recent Minimum Data Set (MDS) assessment dated 10/16/15 coded the resident with a score of 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in | F 309 | | |

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| F 309 | Continued From page 20<br>the skills needed for daily decision making. In the pain section of the MDS, it was coded the staff conducted a pain assessment and that the resident was not offered and/or received as needed (PRN) pain medication. It was assessed that the resident did not receive any non-medication interventions for pain.<br><br>The care plan dated 11/13/15 identified Resident #2 had chronic and acute pain. The goal set for the resident by the staff was that he would demonstrate relief or reduction in pain after receiving interventions. The approaches the staff would use to accomplish this goal included provide comfort measures and administer routine and as needed (PRN) pain medication.<br><br>Resident #2 had the following physician orders for PRN pain medication:<br>-11/25/15 *Hydrocodone 7.5-325 milligrams (mg) 1 tablet every eight hours as needed (PRN) for pain.<br><br>*Hydrocodone is a controlled substance class II narcotic pain reliever with a high potential for abuse. The lower the schedule, the higher potential for abuse (www.drugs.com/schedule-2-drugs.html).<br><br>Review of the clinical record revealed Resident #2 received narcotic pain medication 28 times over the last 3 months (November 2015, December 2015 to current review date of 1/14/16) with no supporting documentation to indicate non-pharmacological measures were implemented prior to administering medication.<br><br>On 1/14/16 at 11:15 a.m., an interview was conducted with the medication administration | F 309 | | |

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| F 309 | Continued From page 21<br>nurse, LPN #2. She stated the resident initiated non-verbal cues and could also tell the nursing staff he was in pain, but there was no documented evidence other measures were tried before narcotic medication intervention.<br><br>On 1/14/16 at 5:45 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated she did expect the staff to try other measures prior to giving PRN pain medication, but she did not have an avenue by which the nurses could document what they do prior to giving PRN pain medication and she doubted if there was documentation in the nurses notes to support offering and trying non-pharmacological interventions prior to giving medication.<br><br>4. The facility staff failed to ensure that the physician orders for the medication Depakote were transcribed and followed for Resident #22.<br><br>Resident #22 was a 54 year old originally admitted to the facility on 2/9/15 and then readmitted on 5/11/15. Resident #22's admitting diagnoses include *Seizures, *Epilepsy and *Depression.<br><br>*Seizures: a hyperexcitation of neurons in the brain leading to abnormal electric activity that causes a sudden, violent involuntary series of contractions of a group of muscles.<br><br>*Epilepsy: a group of neurologic disorders characterized by recurrent episodes of convulsive seizures, sensory disturbances, abnormal behaviors, loss of consciousness, or all of these.<br><br>*Depression: a decrease of vital functional | F 309 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 309 | Continued From page 22<br>activity, a mood disturbance characterized by feelings of sadness, despair, and discouragement resulting from and normally proportionate to some personal loss or tragedy.<br><br>The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.<br><br>The most recent Minimum Data Set (MDS) assessment was an Admission 5 day assessment with an Assessment Reference Date (ARD) of 5/18/15 with a Brief Interview for Mental Status (BIMS) pf a 7 out of a possible 15 which indicated that the resident was moderately cognitively impaired and require assistance with daily decision making.<br><br>The Comprehensive Care Plan for Resident #22 with the original admit date of 2/9/15 documented in part, read as follows:<br><br>Problem<br>2. Seizure Activity/At risk for seizures<br><br>Goal<br>2. Resident will maintain therapeutic levels of anti-convulsant medication through next review date.<br><br>4. Medications as ordered and monitor for effectiveness and any side effects.<br><br>On 1/13/16 at 5:15 p.m. a telephone interview was conducted with Resident #22's sister. During the interview the sister stated, "The first four days he was in the facility he was looking worse, not talking I knew he was different. I asked to see his MAR (medication administration record) and I | F 309 | | |

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| F 309 | Continued From page 23<br>found the mistake, he was not getting the right dose of his depakote."<br><br>*Depakote: is an anticonvulsant, mood stabilizer. It increases the level of gamma-aminobutyric acid in the brain, reducing seizure activity.<br><br>The above definition was derived from McGraw-Hill Nurse's Drug Handbook &7th Edition.<br><br>Resident #22's Hospital Discharge Summary dated 2/9/15 documented in part, read as follows:<br><br>Discharge Medications: Current Discharge Medication List<br>START taking these medications<br><br>divalproex DR (DEPAKOTE) 500 mg (milligrams) PO (by mouth) Take 2 Tabs (tablets) by Mouth Every 12 Hours.<br><br>Each medication on the Hospital Discharge Summary had a check mark beside of, and also a had written note saying 2/9/15 verified Dr. (name) / per (name).<br><br>On the Facility Physician's Order Sheet generated on 2/10/15 at 7:49 a.m. the physician medication order for Resident #22's Depakote read as follows:<br><br>DEPAKOTE DR 500 MG TABLET (DIVALPROEX SODIUM) GIVE 1 TABLET BY MOUTH TWICE A DAY DX (diagnosis): SEIZURE DISORDER.<br><br>At the top of the Facility Physician's Order Sheet there was a handwritten notation which read as follows: 2/10/15 9 PM Chart Ok. (name) R.N. | F 309 | | |

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| F 309 | Continued From page 24<br>(registered nurse)<br><br>Resident #22's Medication Administration Record (MAR) for the month of February 2015 was reviewed. On 2/9/15 the MAR indicated the following physician order for Resident #22: DEPAKOTE DR 500 MG TABLET GIVE 1 TABLET BY MOUTH TWICE A DAY. The medication was initialed as being administered 12 times on the MAR at the above dose. On 2/15/15 the MAR indicated a new physician order for Resident #22's Depkaote. The new order read as follows: DEPAKOTE DR 500 MG TABLET GIVE 2 TABLET BY MOUTH TWICE A DAY.<br><br>A chart review under Physician Orders revealed the following order dated 2/15/15: "Clarification order: Depakote DR 500 mg 2 tablets po (by mouth) q (every) 12 hours" which was signed by the physician.<br><br>The Director of Nursing provided documentation indicating inservice training on Transcribing Physician Orders, Chart Audits, Medication Administration Audits, and Documentation for the month of June 2015.<br><br>The Facility Policy titled "Physician Orders" dated 6/1/15 documented in part, read as follows:<br><br>1. Nurse receiving order is responsible for complete order documentation and communication to the pharmacy.<br>2. Order written on Physician Order Sheet by Nurse or Medical Practitioner.<br>3. Medications placed on EZMAR for specific resident by designated Nurse. Including dosage, medication, route and frequency of administration, stop time and qualifying diagnosis. | F 309 | | |

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| F 309 | Continued From page 25<br>9. Copies of new orders taken to daily clinical meeting. Both DON (Director of Nursing) and Medical Records copies. Orders compared for accuracy.<br>10. Following clinical meeting, DON or designate reviews EZMAR and chart for new order.<br>11. Designated Nurse reviews all charts daily to insure no orders were missed.<br><br>On 1/14/15 at 5:30 p.m. during a pre-exit interview with the Administrator and the Director of Nursing the above findings were shared. The Surveyor asked, "What is your expectation of your nursing staff regarding transcribing physician medication orders when the facility receives new admissions?" The Director of Nursing stated, "One nurse transcribes the orders from the hospital discharge summary and another nurse checks over the orders for accuracy. Then the next morning we bring the chart to the morning meeting and we go through every order and check it against the hospital discharge summary. Also every 24 hours all charge nurses go back and check for any new orders that have come in."<br><br>No further information was provided prior to exit.<br><br>This is a COMPLAINT DEFICIENCY<br><br>3. The facility staff failed to offer non-pharmacological (nursing measures such as repositioning or backrubs) measures prior to the administration of pain medications for Resident #3. | F 309 | | |

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| F 309 | Continued From page 26<br><br>Resident #3 was admitted to the facility on 04/18/14 with a readmission on 01/12/16. Diagnosis for Resident #3 included but are not limited to: Paraplegia (paralysis-loss of muscle function of lower extremities), Stage III sacral decubitus ulcer (pressure sore - area of damaged skin caused by staying in one position for extended periods of time), Diabetes Mellitus (disease where the body's blood sugars are high), Depressive Disorder (serious medical condition that involves the brain), anxiety, psychosis (a severe mental condition that causes abnormal thinking and perceptions), ileostomy (bottom of the small intestine (ileum) is attached to a stoma and exits the abdomen where stool is collected in a bag, colostomy (the colon is attached to a stoma and exits the abdomen where stool is collected in a bag), gun shot injury and bilateral (both sides) lower extremity amputations.<br><br>Resident #3's annual MDS (Minimum Data Set - an assessment protocol) with an ARD (assessment reference date) of 10/10/15 assessed Resident #3 as requiring extensive assistance with one staff member assistance for Dressing and Toileting. Resident #3 was assessed as requiring extensive assistance with two staff person assistance for Bed Transfers and Hygiene. Resident #3 empties urine from a tube inserted into the bladder from the abdomen (supra-pubic) catheter. Resident #3 empties bowels through a colostomy and an ileostomy.<br><br>A review of Resident #3's clinical record indicated Resident #3 has a physician order written on 07/26/15 for Tramadol 50 mg tablet by mouth one tablet every six hours as needed for pain. The Medication Administration Record (MAR) for | F 309 | | |

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| F 309 | Continued From page 27<br>January 2016 indicated that Resident #3 received Tramadol 50 mg thirty times from January 1 to January 12, 2016 at 2:08 a.m. The facility was not able to produce any documentation that non-pharmacological measures were attempted prior to the administration of the pain medication Tramadol or with the administration of the pain medication Tramadol.<br><br>Resident #3's careplan problem of Pain (chronic) initiated on 11/18/15 listed as approaches the following approach: Provide comfort measures: repositioning.<br><br>An interview was conducted with LPN #1 on 01/13/16 at approximately 2:30 p.m. When asked where she would document in the MAR non-pharmacological measures such as repositioning or back rub, she stated: "..no documentation for pain non-pharmacological measures."<br><br>A review of the facility standards book: Lippincott's Nursing Procedures sixth edition pages 542 to 546 noted the following guidelines for pain management was conducted and it noted the following in part:<br><br>Interventions used to manage pain include analgesics, emotional support, comfort measures, and complementary and alternative therapies such as cognitive techniques to distract the patient.<br><br>Work with the patient to develop a nursing care plan using interventions appropriate to the patient's lifestyle. The may include prescribed medications, emotional support, comfort measures, complementary and alternative | F 309 | | |

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| F 309 | Continued From page 28<br>therapies such as cognitive techniques, and education about pain and its management.<br><br>Performing comfort measures: Reposition the patient periodically to reduce muscle spasms and tension and to relieve pressure on bony prominences.<br><br>Give the patient a back massage to help reduce tense muscles<br><br>A review of the facility standards book: Clinical Nursing Skills and Techniques 8th edition Perry and Potter pages 366 through 374 was conducted and noted the following in part:<br><br>Nonpharmacologic Pain Management: Cutaneous Stimulation, Heat and Cold, Relaxation, Guided Imagery, Distraction<br><br>A document provided by the facility on 01/14/16 entitled: "Pain - Clinical Protocol" taken from "Nursing Services Policy and Procedure Manual for Long Term Care 2001 Med-Pass, Inc with a revision date of June 2013, noted the following statement:<br><br>The physician and staff will identify individuals who have pain or who are at risk for having pain. It also includes a review for any treatments that the resident currently is receiving for pain, including complementary (non-pharmacologic) treatments.<br><br>The Facility Administration including the Administrator #1, DON (Director of Nursing) #2, and Corporate Care Consultant #1 was informed of the findings during a briefing on 01/14/16 at approximately 6:15 p.m. No further information | F 309 | | |

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| F 309 | Continued From page 29<br>was provided. | F 309 | | |
| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, facility documentation and staff interviews the facility staff failed to provide supervision for 1 of 25 residents in the survey sample, Resident #13, resulting in harm.<br><br>The facility staff failed to provide supervision to prevent an elopement for Resident #13 resulting in harm.<br><br>The findings included:<br><br>Resident #13 was a 50 year old originally admitted to the facility on 5/20/14 and readmitted on 12/22/15. Resident #13's diagnoses included *Hypoxic Encephalopathy secondary to substance abuse, *Diabetes Mellitus, *Hypertension, *Parkinson's Disease, and *Anoxic Brain Injury secondary to Cardiac Arrest.<br><br>*Hypoxic Encephalopathy: any abnormal condition of the structure or function of brain tissues, due to an acute lack of oxygen supply. | F 323 | Past noncompliance: no plan of correction required. | |

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| F 323 | Continued From page 30<br><br>*Diabetes Mellitus: a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion by the beta cells of the pancreas or resistance to insulin.<br><br>*Hypertension: a common disorder that is a known cardiovascular disease risk factor, characterized by elevated blood pressure over normal values of 120/80 mm Hg (milligrams of mercury) in an adult.<br><br>*Parkinson's Disease: a slowly progressive degenerative neurologic disorder characterized by resting tremor, pill rolling of the fingers, a masklike facies, shuffling gait, forward flexion of the trunk, loss of postural reflexes, and muscle rigidity and weakness.<br><br>*Anoxic Brain Injury: an abnormal condition characterized by a local or systemic lack of oxygen to brain tissue causing injury or irreversible death to the brain tissues.<br><br>The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.<br><br>The most recent Comprehensive Minimum Data Set (MDS) assessment was an Annual assessment with an Assessment Reference Date (ARD) of 5/4/15 with a Brief Interview for Mental Status (BIMS) coded as resident is rarely/never understood. Staff was interviewed for mental status which revealed that Resident #13 had long and short term memory problems and was severely impaired in cognitive skills for daily decision making. Under functional Status | F 323 | | |

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| F 323 | Continued From page 31<br>Resident #13 was extensive one person assist for bed mobility, transfers, walking, and dressing.<br><br>Resident #13's Comprehensive Care Plan was reviewed. The resident had Interdisciplinary Care Plans in place that included Elopement Risk/Exit Seeking and Behaviors. On 10/6/15 both of the Interdisciplinary Care Plans had been reviewed and documented in part read, as follows:<br><br>Elopement Risk/Exit Seeking<br><br>Problem: Resident is at risk for elopement as evidenced by: cognitive impairment, independent mobility/wc (wheelchair), poor decision making skills, exit seeking behavior, wanders oblivious to safety needs.<br><br>Exhibits exit-seeking behavior as evidenced by trying to elope.<br><br>Approaches:<br><br>Use discrete resident identifier, so staff is aware of the resident's elopement risk.<br>Provide staff supervision for resident when attending an out-of-facility activity.<br>Use audible monitoring system to alert staff of exit seeking behaviors.<br><br>The Care Plan also indicated that Resident #13 had a Wanderguard monitoring bracelet in place until 11/11/15 at which time it was discontinued.<br><br>Resident #13's Behavior Care Plan documented in part, read as follows:<br><br>Problem: Behavior Problem Wandering, as evidenced by history of wandering in and out of | F 323 | | |

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| F 323 | Continued From page 32<br>other residents rooms. Attempting to leave unit.<br><br>Approaches:<br><br>Address wandering behavior by walking with or attempt to redirect from inappropriate area; engage in divisional activity.<br>Intervene as needed to protect the rights and safety of others, approach in calm manner; divert attention, remove from situation and take to another location as needed.<br><br>Both Care Plans were reviewed again on 1/12/16. Resident #13 eloped from the facility on 12/17/15, the Wanderguard monitoring bracelet was removed on 11/11/15; however, based on the Care Plan review on 10/6/15 Resident #13 was identified to have elopement, exit seeking, and wandering behaviors.<br><br>The Physician's Progress Note dated and signed 10/2/15 documented in part, read as follows:<br><br>Goes down off floor for activities.<br>Neruo A & O x 1 Person, (alert and orient to person only).<br>Diagnoses: 4. HX (history) Delirium<br><br>Resident #13's Monthly Summary's date 10/10/15, 11/9/15 and 12/9/15 under Cognitive Patterns documented in part, read as follows:<br>Indicators of Delirium: Disorganized thinking checked.<br>Memory: Long-Term Memory problems checked.<br>Daily Decision Making Skills: Moderately Impaired-decisions poor, cues/supervision required.<br><br>Quarterly Nursing Evaluations for Resident #13 | F 323 | | |

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| F 323 | Continued From page 33<br>dated 5/6/15, 5/8/15, and 8/4/15 under Elopement Risk Evaluation each placed the resident at risk for elopement.<br><br>Resident #13's Nurse's Note dated 11/11/15 documented in part, read as follows:<br><br>Resident wanderguard checks and wanderguard d/c'd (discontinued) secondary to resident no longer being an elopement risk. Resident own R/P (responsible party) and made aware, also emergency contact (name) contacted. MD (doctor) also aware and in agreement.<br><br>Resident #13's Nurse's Notes were reviewed for 12/17/15 and documented in part, read as follows:<br><br>4 p.m. Upon making walking around, resident was not in his room. Per off going staff nurse resident was downstairs participating in activities.<br><br>5:35 p.m. Resident was unable to be locate. Code green was called. Facility staff search all units, offices, bathroom and surrounding area, resident was not found.<br><br>6:00 p.m. Facility staff began searching the surrounding neighborhood. Resident was unable to be locate.<br><br>12/18/15<br><br>4:00 a.m. Resident was returned via police who said he was found down by the tracks (railroad tracks) in a puddle of water. Vitals taken 149/96, P (pulse) 92, R (respirations) 16, T (temperature) 94 degrees oral, O2 sats (oxygen saturation) 98 % room air. Resident given blankets to passively | F 323 | | |

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| F 323 | Continued From page 34<br>warm and transferred to ER (emergency room) at (hospital) via ambulance on a stretcher after call to 911.<br><br>Clinical Record review for Resident #13 revealed a Nursing Home To Hospital Transfer Form dated 12/18/15 at 4:00 a.m. documented in part, read as follows:<br><br>Key Clinical Information<br>Relevant Diagnoses: other Delirium<br>Vital Signs B/P: (blood pressure) 149+/96, HR: (heart rate) 92, R (respirations) 16, Temp: (temperature) 94 degrees Time Taken 4:00 a.m.<br>Risk Alerts: other: wandering.<br><br>On 1/13/15 the Director of Nursing presented the surveyor a typed timeline of Resident #13's elopement. The timeline documented in part, read as follows:<br><br>Resident, (Name) on 12/17/15 at 5:10 p.m. exit the facility via wheelchair. He was at an Adhcoc resident council meeting in the dining room located on the first floor. After meeting was completed he waiting to be transported back to the unit. He propelled himself to the front lobby and exit the front door. The receptionist checked the elopement and wandering book for his name and picture which had been removed. On 10/28/15 an elopement evaluation was completed and indicated that he was not at risk.<br><br>The CNA (Certified Nursing Assistant) who was assigned to him went to the dining room to locate him for dinner. He was unable to be located. The CNA asked the receptionist had she seen (Resident #13) and she stated I saw him go out the front door. The CNA called a Code Green. | F 323 | | |

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| F 323 | Continued From page 35<br>The facility and grounds was search an he was unable to be located. Staff on duty and off duty staff search for him on foot and by cars. Norfolk Police was notified and they search the entire neighborhood on foot and cars. A silver alert was issued by the police with a picture and a description. The staff continue to search until 12 midnight. Norfolk Police continue to search.<br><br>I received a call at 3:10 a.m. that the police had located him and they were at the building. I instructed them to take him to (name) hospital for evaluation. I was informed that he was found sleeping beside the railroad tracks. I immediately called his mother at 3:20 a.m. to inform her that he found, where, who, and that I asked the police to take him to ER for evaluation. I informed her that he was talking and no physical harm was noted by police.<br><br>Name (Resident #13) was admitted to MS (medical -surgical) unit.<br><br>The local police Incident/Investigation Report dated 12/17/15 was reviewed. The Incident/Investigation Report stated that Resident #13 was a missing person that was last seen at 17:15 (5:15 p.m.) and was reported missing at 18:00 (6:00 p.m.). The Incident/Investigation Report under the narrative section documented in part, read as follows:<br>Complainant reports listed victim wheeled out of facility at approximately 1710 (5:10 p.m.) hours. Staff was unaware he had left the facility until approximately 18:00 (6:00 p.m.) hours when they call PD (police department). Victim has several medical issues and limited mental status.<br><br>A review of the Prehospital Care Report | F 323 | | |

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| F 323 | Continued From page 36<br>Summary by the City Fire-Rescue documented in part, read as follows:<br><br>Call Received 04:11:34 a.m.<br>Dispatched 04:11:41 a.m.<br>En Route 04:14:24 a.m.<br>On Scene 04:22:07 a.m.<br>Patient Contact 04:23:00 a.m.<br>Left Scene 04:27:24 a.m.<br>At Destination 04:28:39 a.m.<br>Clinical: Dispatch Reason: HEAT/COLD/ALERT/W/O (without) 1ST Party (indicates heat was not the issue).<br><br>Narrative History Text:: Patient with the staff who stated that the PT (patient) was reported missing earlier. Found this morning laying on railroad tracks by police. The PT brought back and the staff wanted him checked out because he was hypothermic. The PT was found out front of the entrance wrapped in blankets. The PT stated he was cold but did not hurt anywhere.<br><br>Name (local hospital) Emergency Department Physician Provided Note dated 12/18/15 at 5:53 a.m. documented in part, read as follows:<br><br>Assessment/Differential Diagnosis: Name (Resident #13) is a 49 year old male with a hx (history) of hypoxic encephalopathy, hypertension, diabetes mellitus, and substance abuse, who had gone missing from his nursing home for several hours and was found soaking wet and cold outside-he is a poor historian-consider Hypothermia.<br><br>ED (emergency department) Course/Medical Decision Making: Initial temperature 96.8 and patient changed into dry clothes and warmed | F 323 | | |

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| F 323 | Continued From page 37<br>repeat temperature 98.1. Patient is awake and answers some questions but is confused and disoriented. Case discussed with name (doctor) who is admitting patient.<br><br>Comments: Name (Resident #13) presents to the ED via NPD (police department) for medical screening. Patient was found outside lying in a puddle near the railroad track. Patient had been a missing person for several hours, is currently staying at (name of facility) but eloped last night. He currently denies any complaints other than being cold.<br><br>Physical Exam:<br>Patient present via EMS (emergency medical services) soaked and disheveled and cold.<br><br>ED Disposition:<br><br>Admit, I have assessed patient risk. The patient will benefit from observation care.<br><br>Resident #13 was admitted to the hospital on 12/18/15<br><br>Resident #13's Hospital Discharge Summary dated 12/22/15 documented in part, read as follows:<br><br>Hospital Course<br>Chief Complaint/History of Present Illness:<br>Name (Resident #13) is a 49 year old old male with a PMH (past medical history) of Hypertension, Diabetes Mellitus, Substance Abuse, Hypoxic Encephalopathy, Cardiac Arrest and status post PEG (feeding tube) presents to the ED via NPD for medical screening. He was found outside in the cold lying on the railroad | F 323 | | |

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| F 323 | Continued From page 38<br>track. He was reported missing since last night from (name of facility). In ED he was hypothermic and found to have elevated WBC (white blood cells). Patient was hydrated, warmed up and was referred for admission to rule out infection.<br><br>Resident #13 was discharged back to the nursing facility on 12/22/15 after spending 5 days in the hospital. Once the resident returned to the facility a wanderguard bracelet was applied because he was assessed as an elopement risk.<br><br>*Hypothermia: an abnormal and dangerous condition in which the oral temperature id below 95 degrees or the rectal temperature is below 96 degrees, usually caused by prolonged exposure to cold or damp conditions. Symptoms include drowsiness, lack of coordination, confusion, and uncontrolled shivering. The person may appear to be dead. People who are very old or very young, people who have cardiovascular problems, and people who are hungry, tired, or under the influence of alcohol are most susceptible to hypothermia. Hospitalization is necessary for evaluating and treating any metabolic abnormalities that may result from hypothermia. Related factors include exposure to a cool or cold environment, illness or trauma, inability or decreased ability to shiver, malnutrition, inadequate clothing, consumption of alcohol, medications causing vasodilation, evaporation from skin in cool environment, decreased metabolic rate, inactivity, and aging.<br><br>The above definition was derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.<br><br>The facility Administrator provided the surveyor | F 323 | | |

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| F 323 | Continued From page 39<br>with a copy of the Facility Reported Incident and the Final Report of Elopement that he submitted to the Virginia Department of Heath Office of Licensure and Certification on 12/17/15 and 12/18/15 for Resident #13. The facility Final Report of Elopement for Resident #13 documented in part, read as follows:<br><br>On 12/17/15 Name (Resident #13) was noticed missing at 5:35 p.m. Tapes were reviewed and resident was observed exiting facility at 5:10 p.m. Aide was looking for Name (Resident #13) and came down to see if he was on the first floor. Elopement Code called and staff searched facility/grounds. Staff assigned to search neighborhood around the building. When we did not find him initially we notified the RP (responsible party), Physician, and Police. Police, Staff, and Detectives searched the area and Silver Alert was issued by Police Department. Resident was found at 3:30 a.m. by workers near commuter train location. 911 notified, Ambulance arrived and transported resident back to facility and was instructed to transport to the hospital where he was admitted for Altered Mental Status.<br><br>The facility has re-assessed all residents for elopement risk. Elopement book verified accurate, staff educated on elopement risk and LOA (leave of absence) policy. We have added staff for 24 hour coverage to monitor first floor access points. All doors, alarms, and wanderguard system inspected to ensure functionality. Monitoring of residents at risk every 2 hours on Elopement and Wandering Resident Monitoring Form.<br><br>The facility Administrator provided the surveyor with documentation stating the weather history for | F 323 | | |

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| F 323 | Continued From page 40<br>12/17/15 and 12/18/15. On 12/17/15 the highest temperature was 70 degrees and the lowest temperature that day was 54 degrees. On 12/18/15 the highest temperature was 60 degrees and the lowest temperature was 42 degrees with 0.41 inches if precipitation recorded.<br><br>The Administrator also provided the surveyor with MapQuest documentation indicating how far Resident #13 was found from the facility when the police found him lying on the railroad tracks. Resident #13 was found by the local police department approximately 4:00 a.m. on 12/18/15, 4 minutes and 0.9 miles from then facility in which his care and supervision was entrusted. Resident #13 was missing from the facility for approximately 11 hours.<br><br>On 1/14/16 at approximately 4:15 p.m. a phone interview was conducted with Resident #13's Attending Physician. During the phone interview the Attending Physician was made aware of Resident #13's documented oral temperature of 94 degrees when he arrived back to the facility on 12/18/15 by the police department. The Attending Physician was asked what does a temperature like that mean. The Attending Physician stated, "He was hypothermic." The surveyor asked, "Can hypothermia cause death?" The Attending Physician stated, "Of course it can if severe enough." The surveyor then asked why Resident #13's wanderguard bracelet was discontinued. The Attending Physician stated, "I have no idea why is was discontinued, usually it is at the request of the facility."<br><br>Facility policy and procedure titled "Care of Wandering Resident" dated 6/1/15 documented in part, read as follows: | F 323 | | |

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| F 323 | Continued From page 41<br><br>2. *Provide safety within the facility.<br>*Prevent the resident from eloping.<br><br>5. Monitor the resident's location with visual checks at a minimum of every 2 hours. Document accordingly.<br><br>Facility policy and procedure titled "Elopement/Wandering" dated 6/1/15 documented in part, read as follows:<br><br>Policy Statement: The intent of the facility is to maintain residents safety by identifying residents who are at risk for wandering/elopement behavior.<br><br>Guideline:<br><br>1. An elopement/wandering assessment will be completed upon admission, located in the nursing admission information packet, and quarterly thereafter.<br><br>2. Any resident displaying significant wandering behavior will be assessed for elopement/wandering risk and care planned appropriately.<br><br>3. Care plans and individual behavior plans will address wandering as a specific problem. Approaches will be formulated, patterns identified (if any), and the causes determined should be addressed.<br><br>4. A wandering/elopement notebook containing pictures and pertinent demographic information will be maintained by social services and kept at the nurses stations. Updates will be done | F 323 | | |

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| F 323 | Continued From page 42<br>quarterly.<br><br>The facility submitted a detailed plan of correction which included, in part:<br>1. Telephone meeting held with family to discuss plans for discharge to secure unit. 12/18/15<br>All doors, alarms, wander guard bracelets, key pads inspected. 12/15/15<br><br>2. 100% of all elopement assessments were reviewed for accuracy and /or completed for each resident assessed to be at risk for elopement. All residents identified as an elopement risk were care planned with interventions specific and appropriate for each resident to match their ability to understand and comprehend. before wanderguard is removed IDT (Interdisciplinary team) will approve. 12/18/15<br><br>3. Elopement books kept at front desk and nurses station were checked for face sheets, pictures. Elopement monitoring forms were reviewed for all residents identified as an elopement risk. Social Worker will update elopement books. Activities will take photos for elopement books. MDS coordinator/SS will ensure elopement care plans are in place. The ADON/nursing will bring all new admissions, re-admissions, to the clinical meeting daily to review. 12/18/15<br><br>4. All concerns will be addressed immediately and reported to QAPI Committee monthly until 100% compliance is achieved. The facility will conduct elopement drill on each shift to review staff actions immediately then monthly and report findings to the QAPI Committee monthly until 100% compliance is achieved. Leave of Absence Ensure 100% compliance - Everyone leaving | F 323 | | |

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| F 323 | Continued From page 43<br>building will sign out and have Dr. order for LOA. Residents will sit in the courtyard instead of out front. 12/18/15<br><br>A pre-exit interview was conducted with the Administrator and the Director of Nursing where the above information was shared. The Administrator discussed his plan of correction that is currently in place and the fact that there has been no further elopements. The surveyor asked, "What would you have expected the staff to have done with the resident after the resident council meeting?" The Administrator stated, "To have helped him back up to his room, he didn't usually come down." The surveyor asked, "Do you think the resident was a appropriately assessed prior to the removal of his wanderguard bracelet?" The Director of Nursing stated, "No, I thought the wanderguard was still on him. I would not have taken it off him." The surveyor asked, "Was there a breakdown in the facility system regarding elopement risk prior to Resident #13 eloping and how has improved?" The Administrator stated, "Yes there was, but now we have new systems, audits and 24 hour monitoring in place.<br><br>No further information was provided prior to exit. | F 323 | | |
| F 333 SS=E | COMPLAINT DEFICIENCY-PAST NON COMPLIANCE<br>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors. | F 333 | Resident #22 has been discharged | |

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| F 333 | Continued From page 44<br>This REQUIREMENT is not met as evidenced by:<br>Based on a complaint investigation, medical record review, family interviews and staff interviews the facility staff failed to ensure that they were free of significant medication errors for 1 of 25 residents in the survey sample, Resident #22.<br><br>The facility staff failed to ensure that Resident #22 was free from a significant medication error by administering the medication ONFI for 16 doses double the physician prescribed amount.<br><br>The findings included:<br><br>Resident #22 was a 54 year old originally admitted to the facility on 2/9/15 and then readmitted on 5/11/15. Resident #22's admitting diagnoses include *Seizures, *Epilepsy and *Depression.<br><br>*Seizures: a hyperexcitation of neurons in the brain leading to abnormal electric activity that causes a sudden, violent involuntary series of contractions of a group of muscles.<br><br>*Epilepsy: a group of neurologic disorders characterized by recurrent episodes of convulsive seizures, sensory disturbances, abnormal behaviors, loss of consciousness, or all of these.<br><br>*Depression: a decrease of vital functional activity, a mood disturbance characterized by feelings of sadness, despair, and discouragement resulting from and normally proportionate to some personal loss or tragedy.<br><br>The above definitions were derived from Mosby's | F 333 | Unit managers or designee to review the residents' physician orders in the EZMAR electronic medication administration record and charts for entree accuracy.<br><br>The SDC in-serviced nursing on new admission reconciliation with hospital and home medications on 1/26/16.<br><br>New admissions charts will be reviewed at daily clinical meetings during the week for accuracy on the EZMAR electronic medication administration records. New telephone orders to be checked and verified for accuracy and transcription by DON/Designee.<br><br>The audits results and any findings will be presented at the QAPI meeting monthly until sustainability is attained.<br><br>Date Certain: 2/14/16 | |

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| F 333 | Continued From page 45<br>Dictionary of Medicine, Nursing, and Health Professions 8th Edition.<br><br>The most recent Minimum Data Set (MDS) assessment was an Admission 5 day assessment with an Assessment Reference Date (ARD) of 5/18/15 with a Brief Interview for Mental Status (BIMS) pf a 7 out of a possible 15 which indicated that the resident was moderately cognitively impaired and require assistance with daily decision making.<br><br>A review of Resident #22's medical record revealed a neurological consult on 5/18/15 with the following new order: Onfi 5 mg (milligrams) bid (twice a day).<br><br>*Onfi: is a a benzodiazepine. Onfi affects chemicals in the brain that may become unbalanced and cause anxiety. Onfi is used in combination with other medications to treat seizures associated with epilepsy.<br><br>The above definitions were derived from facility's pharmacy drug sheets: www.drugs.com.<br><br>Physician order dated 5/18/15 documented in part, read as follows:<br>2. Onfi 5 mg via (by) Peg (feeding tube) Bid (twice a day).<br><br>Resident #22's Medication Administration Record for May 19th through the 30th of 2015 indicated the following physician order for Onfi: ONFI GIVE 5 ML VIA (by) PEG (feeding tube) TWICE DAILY SEIZURE DISORDER. Nurse's signatures indicating that this medication was administered as transcribed on the Medication Administration | F 333 | | |

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| F 333 | Continued From page 46<br>were visualized for the above dates.<br><br>A timeline written by the Director of Nursing regarding Resident#22 was presented to this surveyor. The timeline was reviewed and documented in part, read as follows:<br><br>On 5/31/2015 the day shift notice that the ONFI was transcribe with the wrong dose. The error was 5 ml (milliliter) BID (twice a day) instead of 5 mg (milligram) (2 ml). Dr. (name) was notify immediately and orders received to hold 9 a.m. and 9 p.m. dose for today. On 6/1/15 begin ONFI 5 mg (2 ml) BID. Mrs. (name, resident's sister) was notify of the error.<br><br>On 1/13/16 at 5:15 p.m. an interview was conducted via telephone with Resident #22's sister. During the interview the sister stated, "I was never called and made aware that my brother has been been give double the amount of his ONFI. I understand that errors can happen, but I'm supposed to be called and no one had called to tell me."<br><br>On 1/14/15 at 7 p.m. the Director of Nursing stated, "I can't find the documentation where we called the resident's sister about the medication error, but I can get the nurse on the phone and she can tell you she called." Surveyor stated, "without dated and timed documentation that the sister was called at the time the medication error was noted there is no proof that she was notified."<br><br>A review of Resident #22's Medication Administration Record for May 31, 2015 indicated the following order: ONFI 2.5 MG/ML, GIVE 2 ML VIA PEG 9 AM AND 9 PM START 6/1/2015. | F 333 | | |

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| F 333 | Continued From page 47<br>Physician order dated 5/31/15 documented in part, read as follows:<br><br>1. Hold ONFI (clobazam) today.<br>2. Begin same dose on 6/1/15 (Monday).<br><br>Nurse's Note on 5/31/15 for the 3-11 shift documented in part, read as follows:<br><br>Dr. (name) notified of ONFI administration order: Hold onfi today. Begin same dose 2 ml at 9 am and PM and labs to be drawn.<br><br>Nurse's Note on 6/1/15 for the 7-3 shift documented in part, read as follows:<br><br>Pt. (patient) is day 2/3 med. (medication) error with no adverse reactions noted this shift. Medicine onfi held 5/31 and to restart 6/1/15.<br><br>Resident #22's Controlled Drug Record dated 5/21/15 through 6/2/15 for the medication ONFI 2.5 MG/ML Suspension was reviewed. On the pharmacy label the following instructions were written and hi-lighted in yellow for administration: 2 ML (5 MG) BY MOUTH IN THE MORNING AND 2 ML (5 MG) BY MOUTH IN EVENING**NO REFILL**. Based on the Controlled Drug Record Resident #22 received 16 doses of ONFI 5 ml instead of the physician ordered 2 ml. Based on the physician order for ONFI Resident #22 was to receive 5 mg twice a day, however with the 16 doses that were given at 5 ml the resident received over 10 mg of ONFI per dose given.<br><br>The Director of Nursing provided facility Coaching and Counseling Session documentation dated 6/4/15 which documented in part, read as follows: | F 333 | | |

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| F 333 | Continued From page 48<br>Please describe the Stakeholder's conduct and indicate the specific policy that has been violated.<br><br>Careless mistake that affect the safety of a resident: stakeholder failed to practice proper procedure in carry out of MD (medical doctor) order. Telephone order written on 5/18/15=ONFI 5 mg via peg. tube bid- you transcribed on EZ mar (electronic medication administration record) ONFI 5 ml bid.<br><br>The Coaching and Counseling Session documentation was signed by the Registered Nurse who had made the transcription error.<br><br>The Director of Nursing provided documentation indicating inservice training on Transcribing Physician Orders, Chart Audits, Medication Administration Audits, and Documentation for the month of June 2015.<br><br>The Facility Policy titled "Physician Orders" dated 6/1/15 documented in part, read as follows:<br><br>1. Nurse receiving order is responsible for complete order documentation and communication to the pharmacy.<br>2. Order written on Physician Order Sheet by Nurse or Medical Practitioner.<br>3. Medications placed on EZMAR for specific resident by designated Nurse. Including dosage, medication, route and frequency of administration, stop time and qualifying diagnosis.<br>9. Copies of new orders taken to daily clinical meeting. Both DON (Director of Nursing) and Medical Records copies. Orders compared for accuracy.<br>10. Following clinical meeting, DON or designate reviews EZMAR and chart for new order. | F 333 | | |

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| F 333 | Continued From page 49<br>11. Designated Nurse reviews all charts daily to insure no orders were missed.<br><br>On 1/14/15 at 5:30 p.m. during a pre-exit interview with the Administrator and the Director of Nursing the above findings were shared. The Director of Nursing stated, "There was a transcription error and the wrong dose was given for a few days. I did inservicing with the nursing staff." The Surveyor asked, "What is your expectation of your nursing staff regarding transcribing physician medication orders when the facility receives new admissions?" The Director of Nursing stated, "One nurse transcribes the orders from the hospital discharge summary and another nurse checks over the orders for accuracy. Then the next morning we bring the chart to the morning meeting and we go through every order and check it against the hospital discharge summary. Also every 24 hours all charge nurses go back and check for any new orders that have come in."<br><br>No further information was provided prior to exit. | F 333 | | |
| F 371 SS=F | This is a COMPLAINT DEFICIENCY.<br>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | Items identified 1/12/16 and 1/13/16: Food service and utility carts were cleaned and wheels free of strings on 1/22/16. Walls and floors have be power washed with de-greaser and water filter leak repaired by Plant Ops on 2/10/16. | |

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| F 371 | Continued From page 50<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility staff failed to ensure the kitchen was maintained under sanitary conditions.<br><br>The findings included:<br><br>On 1/12/16 at 7:25 p.m., during the initial inspection of the kitchen, coffee spills were observed on the second shelf of the beverage center and on stored plastic cup lids on the same shelf, there was debris beneath a table beside the deep fat fryer, whitish spillage was observed between the Steamer Chef unit and the oven and the oven was with debris. A large amount of water was observed on the floor on the back wall beside the oven but prior to reaching the sink next to an area where large pans were drying and the wheels of all observed food service and utility carts were with build-up and some with strings hanging from them.<br><br>On 1/13/16 at 11:05 a.m., during the full inspection of the kitchen and accompanied by the Food Service Manager (FSM), the spills between the ice machine and refrigerator remained. The debris beneath the table beside the deep fat fryer, the spills on the cook top stove and the puddle of water below the drying pans were still there as they were the evening before also the utility cart wheels were still soiled and the strings were yet hanging from the wheels.<br><br>On 1/13/16 at approximately 2:10 p.m., the FSM stated the staff had cleaned the identified areas | F 371 | Food Services Manager provided education to dietary staff on proper cleaning of identified areas on 1/22/16.<br><br>Weekly Sanitation check will be completed by the FSM and the Administrator for 4 weeks and monthly thereafter. Food service and utility carts will be audited by FSM for 4 weeks and monthly thereafter.<br><br>The audits results and any findings will be presented at the QAPI meeting monthly until sustainability is attained.<br><br>Date Certain: 2/14/16 | |

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| F 371 | Continued From page 51<br>and they were a clean as possible but the cleaning product had removed the finish from the refrigerator. The FSM further stated the Maintenance Director said the water pooling on the floor next to the drying pan rack was from the water filter system leaking and all they could do for now was to continue to mop it up. The FSM stated there is no policy on cleaning in the kitchen but we reviewed the daily cleaning schedule. The undated Dietary Cleaning Schedule revealed the food carts are thoroughly cleaned on Mondays and wiped cleaned after each meal all other days, the Steamer is cleaned daily, storage shelves are wiped clean every day, utility carts are wiped clean after each use and the refrigerator is wiped clean daily.<br><br>On 1/14/16 at approximately 6:10 p.m. the above findings were shared with the Administrator, Director of Nursing and the Corporate Care Consultant. No further information was provided. | F 371 | | |
| F 387 SS=D | 483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT<br><br>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.<br><br>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, clinical record review, staff interview, and review of the facility's policy | F 387 | Resident # 11 was seen by attending physician on 1/5/16.<br><br>All residents at the center have the potential for this deficiency. Therefore, Medical Records coordinator will audit physician visits compliance upon admission and as required. | |

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| F 387 | Continued From page 52<br>the facility staff failed to ensure 1 of 25 Residents (#11) in the survey sample was seen by a physician or his/her designee at least once every 30 days for 90 days and every 60 days thereafter.<br><br>The Findings include:<br><br>Resident #11 was originally admitted to the facility 4/1/15 and has not been discharged from the facility since this admission. The current diagnoses are vascular dementia, hypertension, peripheral vascular disease, schizophrenia, an anxiety disorder, benign prostate hypertrophy, a seizure disorder, glaucoma, and a vitamin D deficiency.<br><br>The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/31/15 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired for daily decision making.<br><br>Review of the clinical record revealed Physician progress notes dated 4/14/15, 7/14/15, and 8/21/15.<br><br>Registered Nurse (RN) #1 was asked if there were progress notes which had been removed from the clinical record. RN #1 replied she would investigate further and find out what the facility's policy for Physician's visits stated. Upon return RN#1 stated there was one other visit made by the physician and handed the surveyor the progress note. The progress note was dated 1/5/16. RN#1 stated the Medical Records Clerk had not put the progress note on the clinical | F 387 | The current monitoring process has been revised and a reminder letter is sent to physicians following phone call requests.<br>CEO and Medical director will be notified on non- compliance.<br><br>The audit results and any findings will be presented at the QAPI meeting monthly until sustainability is attained.<br><br>Date Certain 2/14/16 | |

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| F 387 | Continued From page 53<br>record yet.<br><br>An interview was conducted with the Medical Records Clerk on 1/14/16 at approximately 7:00 p.m. The Medical Records Clerk stated the physicians are notified when a resident is coming due for a required visit. The Medical Records Clerk further stated Resident #11 physician was aware he was not completing the visits as required but he had plans to get caught up.<br><br>The facility's undated policy entitled Physician Services stated at Guideline #5; The resident will be seen by a physician at least every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The initial comprehensive history and physical is to be completed by the physician and then every other subsequent required visit and be completed by a Nurse Practitioner or Physician's Assistant.<br><br>On 1/14/16 at approximately 6:10 p.m. the above findings were shared with the Administrator, Director of Nursing and the Corporate Care Consultant. No further information was provided. | F 387 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections | F 441 | | |

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| F 441 | Continued From page 54<br>in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations during medication administration and review of facility policy facility staff failed to properly wash hands to prevent the transmission of infection and contamination for two residents (#17 and #18 ) of a survey sample of 25 residents.<br><br>The findings included:<br><br>1. During a medication administration observation | F 441 | All residents at the center have the potential for this deficiency. Therefore, all stakeholders have been in-serviced on Hand Washing policy& procedure with completed competencies as of 1/22/16.<br><br>The U.M. will conduct hand washing observation audits 3 times a week for one month, then monthly for 3 months.<br><br>The audits results and any findings will be presented at the monthly QAPI meeting until sustainability is attained.<br><br>Date Certain: 2/14/16 | |

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| F 441 | Continued From page 55<br>on 1/13/16 at approximately 9:40 am LPN #5 was observed washing hands after administration of medications for Resident #18. LPN #5 was observed to wash hands for only 10 seconds and turned off the water with hands prior to getting a towel to dry hands.<br><br>2. During a medication administration observation on 1/13/16 at approximately 10 am, LPN #5 was observed washing hands after administration of medications for Resident #17. LPN #5 was observed to wash hands for only 10 seconds and turned off the water with hands prior to getting a towel to dry hands.<br><br>According to the facility Handwashing Guideline Steps given by Administration on 1/14/16 states, "...Work up lather cleansing in front and back to hands, between fingers, around cuticles, under nails and up wrist (hands-width). Continue for 20 seconds..." and after washing, "use a dry paper towel to turn off faucet, without contaminating hands by touching sink."<br><br>Another facility policy for Medication Administration General Guidelines state, "...Hands are washed with soap and water again after administration and with any resident contact." According to the Center for Disease Control guidelines for Hand Hygiene in health-care settings (MMWR 2001, volume 51) Handwashing: "Wet hands with water, apply soap, rub hands together for at least 15 seconds..Rinse and dry with disposable towel and use towel to turn off faucet...the duration of the entire process to maintain professional standard for handwashing is 40-60 seconds." | F 441 | | |
| F 465 | 483.70(h) | F 465 | | |

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| F 465 SS=D | Continued From page 56<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interview, the facility staff failed to maintain a safe, clean and sanitary environment.<br><br>1. The facility staff failed to ensure the kitchen and dry storage room floors were kept in a clean and sanitary manner.<br><br>2. Two areas of broken floor tiles in Resident #3's room was observed during survey of the facility on 01/12/16 through 01/14/16.<br><br>The findings included:<br><br>1. During the initial tour of the kitchen and the dry storage room on 1/12/16 at approximately 7:25 p.m. and again on 1/13/16 at approximately 11:05 a.m. with the Food Service Manager (FSM) the kitchen and dry storage room floors were dirty. In the kitchen spills were observed on the floor between the refrigerator and ice machine, crumbs were observed behind the deep fat fryer and cook top stove and the entire perimeter of the kitchen floor was covered with a thick dark brown substance. The floor drain in front the 3 compartment sink was also with a massive amount of debris which prevented it from draining. | F 465 | The two areas of broken floor tiles in Resident #3's room that were identified during survey were replaced on 1/15/16.<br><br>To ensure the deficient practice does not, the center leadership will complete walking rounds weekly on assigned rooms, any identified areas will be corrected and the audit tools will be reviewed weekly.<br><br>The identified areas were cleaned immediately.<br>Food Services Manager provided education to dietary staff on proper cleaning of identified areas on 1/22/16.<br><br>Weekly Sanitation check will be completed by the FSM and the Administrator for 4 weeks and monthly thereafter. Floors will be audited by FSM for 4 weeks and monthly thereafter.<br><br>The audits results and any findings will be presented at the QAPI meeting monthly until sustainability is attained.<br><br>Date Certain: 2/14/16 | |

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| F 465 | Continued From page 57<br>Also during the initial observations of the dry storage room on 1/12/16 at approximately 7:25 p.m. and again during observation rounds with the FSM on 1/13/16 at approximately 11:05 a.m. a single serve condiment package, pasta, dust and debris was observed under the shelves in the dry storage room. Beneath the shelf with the soy sauce and other liquid condiments was a dark brown substance which had dripped on to the floor. The FSM stated at 11:05 a.m. a staff member would be going in to clean the dry storage room. The FSM asked a food service employee walking in the corridor between the dry storage room and the kitchen to go in and clean the dry storage.<br><br>An interview was conducted with the FSM on 1/13/16 at approximately 11:25 a.m. The FSM stated a company had come in and steamed the kitchen floor but even the steamer could not remove all the debris. The FSM further stated she was told by the steaming company the floor tiles were 50 years old and some of the stains could not be removed. The FSM also stated there was no ongoing capital project to replace the kitchen floor tiles but the staff would continue to work on keeping them as clean as possible.<br><br>On 1/14/16 at approximately 6:10 p.m. the above findings were shared with the Administrator, Director of Nursing and the Corporate Care Consultant. No further information was provided.<br><br>2. Two areas of broken floor tiles in Resident #3's room were observed during survey of the facility from 01/12/16 through 01/14/16.<br><br>Resident #3 was admitted to the facility on 04/18/14 with a readmission date of 01/12/16. | F 465 | | |

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| F 465 | Continued From page 58<br>Diagnoses for Resident #3 included but are not limited to: Paraplegia (paralysis-loss of muscle function of lower extremities), Bilateral (both sides) lower extremity amputations, anxiety, Pychosis (a severe mental condition that causes abnormal thinking and perceptions and gun shot injury.<br><br>Resident #3's annual MDS (Minimum Data Set - an assessment protocol) with an ARD (assessment reference date) of 10/10/15 assessed Resident #3 as requiring extensive assistance with one staff member assistance for Dressing and Toileting. The MDS indicated that Resident #3 does not ambulate and is wheel chair bound when out of bed.<br><br>On initial tour on 01/12/16 at approximately 7:30 p.m. two areas of cracked floor tiles were noted in Resident #3's bedroom. One was noted at the foot of his bed measuring approximately 8 by 8 inches and the second at the upper end of his bed measuring approximately 5 by 5 inches. The two areas of broken tiles were noted again on 01/14/16 at approximate 3:00 p.m.<br><br>The cracked floor tile area at the base of Resident #3's bed created an uneven surface which poses a fall risk hazard for those ambulating in the room. The uneven surface area also poses a sanitary condition for dust and debris to settle within the cracked tile areas.<br><br>Review of a facility document entitled, "Housekeeping and Laundry service Cleaning Schedule" indicated that floor care cleaning schedule is performed daily (sweeping and mopping). A document provided by the facility on 01/14/16 entitled: "Instructions Resident | F 465 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SIGNATURE HEALTHCARE OF NORFOLK | 1005 HAMPTON BLVD NORFOLK, VA 23507 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 465 | Continued From page 59<br>rooms and Restrooms: Inspection" noted that Resident Rooms are to have a check of flooring for damaged or loose tiles done monthly.<br><br>An interview was conducted with the Maintenance Director #3 on 01/14/16 who reports that the cracked areas in Resident #3's room will be repaired on 01/15/16.<br><br>The above findings were shared with the Administrator #1, the Director of Nursing #2, and the Corporate RN Care Consultant #1 during a briefing conducted 01/14/16 at 6:15 p.m. No further information was provided. | F 465 | | |