STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495393	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SITTER AND BARFOOT VETERANS CARE CENTER	1601 BROADROCK BLVD RICHMOND, VA 23224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/27/16 through 9/29/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 200 certified bed facility was 194 at the time of the survey. The survey sample consisted of 27 current Resident reviews (Residents 1-27) and 3 closed record reviews (Residents 28-30).	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure one Resident (Resident #19) in a survey sample of 30 Residents was afforded his right to self administer medications. Resident #19 was observed administering his Spiriva inhaler without a physician's order, assessment for ability to self administer medications, nor care plan. The findings included:	F 176	RECEIVED OCT 26 2016 VDH/OLC F 176 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Resident # 19 has been assessed by the Interdisciplinary Team (IDT). MD order has been obtained and careplan updated.	

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

Robyn Jennings | Administrator | 10/20/16

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 176	Continued From page 1 Resident #19, a male, was admitted to the facility 12/7/15. His diagnoses included blepharitis, gastroesophageal reflux disease, hypertension, sleep disorder, hyperlipidemia, congestive heart failure, hypertension, anxiety, seizures, arteriosclerotic cardiovascular disease, atrial fibrillation, and depression. Resident #19's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/16/16 was coded as a quarterly assessment. Resident #19 was coded as having no memory deficits and was able to make his own daily life decisions. Resident #19 was coded as being independent or requiring standby assistance of one staff member to perform his activities of daily living with the exception of bathing. For bathing, he was coded as needing total assistance of one staff. Resident #19 was observed during the medication pour and pass observation 9/28/16 at 9:20 a.m. LPN (licensed practical nurse) A prepared Resident #19's medications at the medication cart. The medications included pills and tablets, inhaler, and nebulizer treatments. LPN A entered Resident #19's bedroom and handed him a cup of oral medications. After taking the oral medications, LPN A prepared the Spiriva inhaler and handed the inhaler to Resident #19. Resident #19 self-administered one puff of the inhaler and attempted to hand the inhaler back to LPN A. LPN A advised Resident #19 he needed to take another inhalation. Resident #19 took the puff and handed the inhaler back to LPN A. LPN A prepared the nebulizer treatment, put the mask on Resident #19, and left the room.	F 176	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. a. All residents who have the ability to self administer medications have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a. Licensed nurses will be educated on the process for self administration of medications. b. The IDT team will follow the established policy and assess residents that wish to self administer medication. 4. Licensed nurses will be educated during orientation and annually on the process for self administration of medications. 5. 11/9/2016	

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SITTER AND BARFOOT VETERANS CARE CENTER	1601 BROADROCK BLVD RICHMOND, VA 23224

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F 176	Continued From page 2	F 176		

Review of Resident #19's clinical record revealed a signed physician's order that included, "Spiriva Handihaler one inhalation daily." An accompanying entry was placed on the eMAR (electronic medication administration record) with nurses' initials indicating the medication had been administered daily. No physician's order was evident for Resident #19 to self-administer the inhaler.

A thorough review of the clinical record revealed no evidence Resident #19 had been assessed for his ability to self-administer the inhaler. Review of the comprehensive care plan, also revealed no care plan had been developed for Resident #19 to self administer medications.

LPN A said, 9/28/16 at 10:10 a.m., she always administered Resident #19's medications the same way. LPN A stated she did not realize that handing the inhaler to Resident #19 was considered self administering medications..

Review of the facility's policy entitled "Self-Administration of Medication" included:

"PROCEDURE

Note: The self administration of medication evaluation will be completed only on those residents that voice a desire to self-administer medication.

1. Verify the resident's desire to self-administer medications and the specific medication he or she wants to self-administer.
2. The social worker will complete the Mini-Mental state examination. Only residents with a score of 24 or above will be considered for

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F 176	Continued From page 3	F 176		

self-administration of medications.

3. If the resident does not score 24 or above on the Mini-Mental Examination, the Evaluation for the Self-Administration of Medication need not be completed. Notify the physician and document the date and time of notification and the physician's response in the progress notes.

4. The licensed nurse will explain the purpose of and complete the Evaluation for Self-Administration of Medications addressing each area of the evaluation criteria.

5. The Interdisciplinary Team will review the evaluation once it is complete and sign the bottom portion of the form.

6. If the Interdisciplinary Team determines that the resident is capable to self-administer medications, a physicians order will be obtained that specifies which medication may be self-administered, as well as whether the resident will keep the medication in his/her room.

7. If the Interdisciplinary Team and/or the physician do not agree the resident is able to self-administer medications, the licensed nurse or social worker should write a detailed explanation on the back of the evaluation form which explains the rationale behind the decisions. The rationale should be explained to the resident by the physician, the licensed nurse, or the social worker.

8. If the resident has been evaluated as appropriate to self-administer medication, update the care plan to reflect this, along with any special consideration. Include whether or not the medications will be kept in the resident's room.

9. Ensure the provision...."

The administrator and ADON (assistant director

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SITTER AND BARFOOT VETERANS CARE CENTER	1601 BROADROCK BLVD RICHMOND, VA 2322[illegible]

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F 176	Continued From page 4 of nursing) were informed, 9/28/16 at 3:30 p.m., of the failure of the staff to ensure Resident #19 was assessed for the safety of self-administering medications, to obtain a physician's order for self administration of medication, and to develop a care plan regarding Resident #19 self administering his inhaler.	F 176		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, observation, facility documentation, and clinical record review, the facility staff failed to develop a comprehensive plan of care for one Resident	F 279	F 279 1a. The careplan for Resident # 17 was updated to include the use of hearing aids. 2a. All residents with hearing devices have the potential to be affected. 3a. The IDT team will be educated on developing careplans to include the use of assistive devices. 3b. Careplans will be reviewed quarterly by the IDT team to ensure careplans accurately reflect the resident. 4a. The QA Nurse / designee will audit two careplans a week for the use of assistive devices for three months. Any discrepancies will be corrected and staff educated as needed. 4b. Results of the audit will be brought to the QA committee for three months to determine if further action is needed. 5a. 11/9/2016	

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F 279	Continued From page 5 (Resident #17) in a survey sample of 30 Residents. For Resident #17, the facility staff failed to develop a comprehensive care plan to include the use of hearing aids. The findings included: Resident #17 was admitted to the facility on 12/30/13 and readmitted after hospitalization on 3/23/15. Diagnoses included diabetes, hypertension, depression, legal blindness, and heart disease. Resident #17's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/30/16 was coded as a quarterly assessment. Resident #17 was coded a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact. Resident #14 was also coded as needing limited to total assistance of one staff member to perform his activities of daily living. He was coded as using hearing aids. Resident #17 was observed on initial tour of the facility on 9/27/16 at 3:30 p.m., on 9/28/16 at 8:15 a.m., and on 1:15 p.m. At all observations, he had a clear colored hearing aid in each ear. On 9/27/16 at 3:30 p.m., Resident #17 stated, "And I got some hearing aids since I've been here. I'm hearing really good now." On 9/28/16 at 9:00 a.m., a review of Resident #17's clinical record was conducted. A review of the comprehensive careplan did did reveal a care plan for the use of his hearing aids. A review of Resident #17's progress notes	F 279		

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F 279	Continued From page 6 revealed the following note dated 4/30/16, "Pt (patient) had appt (appointment) with the hearing clinic at 9:30 a.m. and returned back at 11:00 a.m. Pt. returned with hearing aids in both ears. Hearing aids are functional and resident stated they are very effective. Will continue with current plan of care at this time." On 9/28/16 at 4:30 p.m. during an end of day briefing, the Administrator and the DON (Director of Nursing) were informed of Resident #17's comprehensive care plan that did not include his use of hearing aids. On 9/29/16 at 10:00 a.m., the MDS coordinator, RN (registered nurse) E, was interviewed regarding Resident #17's comprehensive care plan. RN E said Resident #17 never exhibited problems with his hearing. RN E stated, "He just showed up wearing hearing aids after an appointment back in April. It (the care plan) was just missed." A review of the facility's policy entitled 'Care Plan', under Procedures read, "7. The Care Plan is reviewed and updated as necessary, but not less than quarterly or when there is a change in the resident's condition." On 9/29/16 at 12:15 p.m., the Administrator, and the DON were informed of the failure of the staff to develop a comprehensive care plan for Resident #17 that included the use of hearing aids.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281	F 281 1a. Resident # 13 MD was notified 10/13/16. Orders were modified. 1b. Resident # 25 MD was notified 10/14/16. Insulin orders were clarified.	

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F 281	Continued From page 7 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to follow professional standards of nursing for medication administration, for 2 Residents (Resident #13 and Resident #25) in a survey sample of 30 residents. 1. For Resident #13, the facility staff failed to ensure medications were administered. 2. For Resident #25, the facility staff failed to clarify sliding scale insulin orders. The findings included; Resident #13, was admitted to the facility on 10-7-15. Diagnoses included; hyperlipidemia, chronic obstructive pulmonary disease (COPD), type II diabetes mellitus, hypertension, stroke (CVA) cerebrovascular accident, and depressive disorder. Resident #13's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6-28-16 was coded as a quarterly assessment. Resident #13 was coded as having no memory deficits and was able to make his own daily life decisions. Resident #13 was also coded as needing extensive to total assistance of one staff member to perform activities of daily living. Review of Resident #13's eMAR (electronic medication administration record), Nursing progress notes, and the facility "Resident Leave	F 281	2a. All residents have the potential to be affected. 3a. Licensed nurses will be educated on the following: following Physician orders, completing documentation following medication administration, clarifying orders as needed, following the six rights of medication administration (right medication, right dose, right patient, right route, right time, right documentation), and medication administration for residents on frequent LOA (leave of absence). 3b. The Unit Manager / designee will review new insulin orders daily to ensure order is clear. Questionable orders will be clarified with the Physician as needed. Nurses will be educated on clarifying orders if indicated. 4a. The QA nurse / designee will audit four charts (MARs) a week for three months for review of missed medications due to LOA to determine if other arrangements for medications can be made and discuss with MD as needed.	

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F 281	Continued From page 8 of Absence (LOA) Tracking form", revealed evidence that he was not administered the following medications, on the following days, and the reasoning given by staff for the omissions; 9-6-16 Fluticasone (seasonal allergic rhinitis) at 9:00 a.m. and Advair (COPD) at 9:00 a.m., both omitted and the reason was given as "#9 See nursing note". The nursing note stated "being refilled by pharmacy". 9-7-16 Gabapentin (neuropathy) at 1:00 p.m., and Baclofen at 2:00 p.m., both omitted and the reason was given as "#3 Absent from home". There were no nursing notes for this day, and the LOA tracking note did not show the Resident as being signed out at all for that day. 9-13-16 Aspirin (long term use), calcium (supplement), multivitamin (supplement), effexor (major depression), fluticasone (seasonal rhinitis), hydrochlorothiazide (hypertension), lidocaine (knee pain), loratidine (seasonal rhinitis), norvasc (hypertension), and vitamin D (supplement), which was to be administered only once per day each according to physician's orders at 9:00 a.m. There were no nursing notes regarding the omission for this day, and the LOA tracking note showed the Resident checked out at 8:45 a.m., and again at 12:00 noon. This revealed that the 9:00 a.m. medications could have been administered before the Resident left at 8:45 a.m., or when the Resident returned which would have been before he checked back out at 12:00 noon., as these medications were only given once per day. Also, the Resident did not receive advair (COPD) at 9:00 a.m., colace (constipation) at 9:00 a.m.,	F 281	4b. The QA nurse / designee will audit two charts a week of residents that receive insulin to ensure orders are clear for three months. 4c. Results of the audit will be brought to the QA committee for three months to determine if further action is needed. 5a. 11/9/2016	

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F 281	Continued From page 9	F 281		

glucophage (diabetes) at 9:00 a.m., gabapentin (neuropathy) at 9:00 a.m., and situssin (cough) at 9:00 a.m., on 9-13-16, which were ordered multiple times per day, however, could have been administered at 8:45 a.m. before the Resident checked out.

9-17-16 Plavix (cerebrovascular disease) at 5:00 p.m., and gabapentin (neuropathy) at 5:00 p.m.. There were no nursing notes regarding the omission for this day, and the LOA tracking note showed the Resident checked out at 1:00 p.m., however does not indicate when the Resident returned. The plavix medication was a once per day medication, and the record indicated that all 9:00 p.m. medications were administered to this Resident, and this medication could have been administered when he returned.

9-18-16 Plavix (cerebrovascular disease) at 5:00 p.m., There were no nursing notes regarding the omission for this day, and the LOA tracking note showed the Resident checked out at 10:05 a.m., and the Resident returned at 7:45 p.m.. The plavix medication was a once per day medication, and the record indicated that all 9:00 p.m. medications were administered to this Resident, and this medication could have been administered when he returned.

9-20-16 Baclofen (muscle spasm) at 2:00 p.m., and gabapentin (neuropathy) at 1:00 p.m. Nursing notes regarding the omissions for this day revealed that the Resident left early and "returned after lunch". The LOA tracking note showed the Resident checked out at 9:20 a.m., however does not indicate the exact time the Resident returned. These 2 medications were ordered to be given after lunch, and were not.

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

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F 281	Continued From page 10 The Resident would not have received these medications again until 10:00 p.m. for the baclofen, and 5:00 p.m. for the gabapentin, and these medications could have been administered, "after lunch". 9-24-16 Plavix (cerebrovascular disease) at 5:00 p.m., and gabapentin (neuropathy) at 5:00 p.m. Nursing notes regarding the omissions for this day revealed that the Resident "returned at 8:15 p.m.". The LOA tracking note showed the Resident checked out at 1:05 p.m.. The plavix was a once a day medication, and could have been administered upon the Resident's return to the facility. A thorough review of Resident #13's clinical record revealed no evidence he refused the medications. On 9-28-16 at 2:30 p.m., the Director of Nursing (DON) and Administrator were interviewed, and stated they would look into the discrepancy. The DON delivered a copy of the E-MAR, LOA Tracking record, and nursing notes. When interviewed the DON stated that the once per day medications could have been administered, and the doctor could be called to ok administration of one time per day meds to be given at a different time than what was originally planned, so that they would not be missed, she stated "it is what it is." The Director of Nursing (DON) and Administrator provided the facility policy which stated "Verify the medication is being administered at the proper time, prescribed dose, and by the correct route. Resolve any concerns about the medication with the provider, prescriber, and/or staff involved with	F 281		

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F 281	Continued From page 11	F 281		

the patient's care". The Administrator stated "Potter Perry" as their nursing standard.

Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

1. The right medication
2. The right dose
3. The right client
4. The right route
5. The right time
6. The right documentation."

The administrator and DON (director of nursing) were informed of the failure of the staff to ensure medications were administered on numerous days in September 2016, to Resident #13 at the end of day debriefings on 9-28-16 and 9-29-16.

2. For Resident #25, the facility staff failed to clarify sliding scale insulin orders.

Resident #25, an 80 year old, was admitted to the facility on 2/1/16. His diagnoses included diabetes, chronic kidney disease and hypertension.

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	495393	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SITTER AND BARFOOT VETERANS CARE CENTER	1601 BROADROCK BLVD RICHMOND, VA 23224

(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 281	Continued From page 12	F 281		

Resident #25's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7/26/16. He was coded with a Brief Interview of Mental Status score of 12 indicating moderate cognitive impairment.

According to the clinical record and the September 2016 Medication Administration Record (MAR), Resident #25 had the following physician orders for insulin administration:
1. Lantus, inject 40 units one time a day, do not hold (9:00 a.m.)
2. Humulin R, inject 10 units one time a day (9:00 a.m.)
3. Humulin R, inject 16 units one time a day, HOLD if lunch intake is <25% (11:30 a.m.)
4. Humulin R, inject 16 units one time a day (4:30 p.m.)
5. Humulin R, inject per sliding scale three times per day (6:30 a.m., 11:30 a.m., 4:30 p.m.):
0-70= 0 units, notify MD (doctor)
71-90= 0 units, subtract 1 unit from the meal dose
91-150= 0 units, give along with scheduled meal dose
151-200= 2 units, give along with scheduled meal dose
201-250= 4 units, give along with scheduled meal dose
251-300= 6 units, give along with scheduled meal dose
301+= 8 units, call MD for blood glucose greater than 400

Issues with the administration of the insulin orders included:

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F 281	Continued From page 13 A. Actual meal times and Humulin R sliding scale insulin administration times do not correspond. Resident #25 ' s Humulin R sliding scale insulin order read " give along with scheduled meal dose " . According to the September 2016 MAR, Resident #25 was scheduled to receive Humulin R sliding scale insulin at 6:30 a.m., 11:30 a.m., 4:30 p.m. The facility served meals at the following times: Breakfast= 7:45 a.m. Lunch= 12:00 p.m. Dinner= 5:15 p.m. According to the administration times for the Humulin R sliding scale insulin order and the meal times, Resident #25 was receiving the sliding scale insulin before he was scheduled to eat his meals. The scheduled lunch dose of Humulin R included an extra parameter " HOLD if lunch intake is <25% " . The lunch dose of sliding scale Humulin R was scheduled before the lunch service. It is unclear if Resident #25 ' s lunch intake was being assessed prior to the administration of the 11:30 a.m. sliding scale Humulin R. B. Administration times for Humulin R sliding scale did not correspond with the scheduled doses of Humulin R (per physician order). The Humulin R sliding scale order included the following " 71-90= 0 units, subtract 1 unit from the meal dose " . The " meal dose " in the sliding scale order is in reference to the scheduled doses of Humulin R administered at meal times. Humulin R sliding scale was administered at 6:30 a.m., 11:30 a.m., and 4:30 p.m. The Humulin R scheduled doses were administered at 9:00 a.m.,	F 281		

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F 281	Continued From page 14	F 281		

11:30 a.m., and 4:30 p.m. The times of the scheduled Humulin R and the sliding scale Humulin R do not correspond. Sliding scale insulin administered at 6:30 a.m. did not have a corresponding scheduled meal dose of insulin. Because the sliding scale Humulin R insulin and the scheduled Humulin R insulin administration times did not correspond, the sliding scale parameters could not be implemented per physician order.

C. Insulin was not administered per physician order.

Sliding scale insulin administration and blood sugar readings were documented on the September 2016 MAR as follows:

9/28/16 (11:30 a.m.) 72, 0 units

Licensed Practical Nurse C (LPN C) was the nurse who completed the documentation on the MAR on 9/28/16 (11:30 a.m.). According to the MAR, LPN C measured a blood sugar of 72 and gave 0 units of sliding scale coverage. According to the sliding scale, it was correct that 0 units of insulin be administered. But the sliding scale order also indicated that 1 unit of insulin should have been subtracted from the meal dose. The " meal dose " referred to the scheduled meal dose of insulin, Humulin R inject 16 units one time a day.

According to the September 2016 MAR, the scheduled Humulin R 16 units was not administered. Instead of subtracting 1 unit of insulin from the meal dose (per sliding scale order), LPN C held the 16 units of Humulin R scheduled at 11:30 a.m.

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F 281	Continued From page 15 LPN C was interviewed on 9/29/16 at 10:55 a.m. She was asked to review the sliding scale order, specifically "71-90= 0 units, subtract 1 unit the meal dose". LPN C was asked what " meal dose " meant. LPN C stated that the meal dose referred to the breakfast dose. It was reviewed with LPN C that the blood sugar reading of 72 was measured at 11:30 a.m.. LPN C was asked if the " meal dose " at 11:30 a.m. referred to the scheduled lunch time dose of Humulin R. She again stated that the "meal dose" referred to the breakfast meal. When asked why she held the scheduled dose of Humulin R at 11:30 a.m., she stated she held the insulin because she felt the blood sugar was low. Fundamentals of Nursing, 6th Edition, Potter-Perry, page 419, provides the following guidance regarding physicians ' orders, " The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians ' orders unless they believe the orders are in error or would harm the clients. Therefore all orders must be assessed, and if one is found to be erroneous or harmful, further clarification from the physician is necessary. " On 9/29/16 at 11:15 a.m., Resident #25's sliding scale order was reviewed with the Director of Nursing (DON). The interview conducted with LPN C was also reviewed with the DON. The DON was notified that LPN C did not appear to understand the Humulin R sliding scale order and had not implemented the order per the parameters during the 9/28/16, 11:30 a.m. administration. It was also reviewed that sliding scale insulin to be administered at 6:30 a.m. did	F 281		

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F 281	Continued From page 16 not have a corresponding meal dose. The DON agreed that the order needed to be clarified. The Administrator stated on 9/28/16 at about 2:30 PM that "Potter Perry" was their nursing standard. At the end of day meeting on 9/29/16, the insulin orders were reviewed with the DON and Administrator. No further information was provided.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure the highest practicable well being for 3 Residents (Residents #13, #25, and #24) in a survey sample of 30 residents. 1. For Resident #13, the facility staff failed to ensure multiple medications were administered per physician's order. The medications are as follows: Fluticasone; Gabapentin; Aspirin; calcium; multivitamin; effexor; fluticasone; hydrochlorothiazide; lidocaine; loratidine; norvasc;	F 309	F 309 1a. Resident # 13 MD was notified 10/13/16. Orders were modified. 1b. Resident # 25 MD was notified 10/14/16 and order was clarified. 1c. Resident # 24 MD was notified 10/13/16 with no new orders. 2a. All residents have the potential to be affected.	

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F 309	Continued From page 17 and vitamin D 2. For Resident #25, the facility staff failed to administer insulin per physician order. 3. The facility staff failed to administer Resident #24's Clonidine per the physician orders. Clonidine was administered when Resident #24's heart rate was less than or equal to 60, contrary to physician orders. The findings included: 1. Resident #13, was admitted to the facility on 10-7-15. Diagnoses included; hyperlipidemia, chronic obstructive pulmonary disease (COPD), type II diabetes mellitus, hypertension, stroke (CVA) cerebrovascular accident, and depressive disorder. Resident #13's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6-28-16 was coded as a quarterly assessment. Resident #13 was coded as having no memory deficits and was able to make his own daily life decisions. Resident #13 was also coded as needing extensive to total assistance of one staff member to perform activities of daily living. Review of Resident #13's eMAR (electronic medication administration record), Nursing progress notes, and the facility "Resident Leave of Absence (LOA) Tracking form", revealed evidence that he was not administered the following medications, on the following days, and the reasoning given by staff for the omissions; 9-6-16 Fluticasone (seasonal allergic rhinitis) at	F 309	3a. Licensed nurses will be educated on the following: following Physician orders, completing documentation following medication administration, care of a diabetic resident (holding insulin, following parameters), clarifying orders, medication administration for residents on frequent LOA, and on following the six rights of medication administration (right medication, right dose, right patient, right route, right time, right documentation). 3b. Unit Managers will review physician orders written the previous day to ensure orders are accurate and that vitals are able to be documented on the MAR if indicated. Orders will be corrected if needed and the nurse that entered the order will be educated as needed. 4a. The QA Nurse / designee will audit four charts (MARs) of residents that receive insulin (scheduled and or sliding scale) a week for three months for review of blood sugar monitoring and administration. Nurses will be educated as needed if discrepancies are noted.	

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F 309	Continued From page 18 9:00 a.m. and Advair (COPD) at 9:00 a.m., both omitted and the reason was given as "#9 See nursing note". The nursing note stated "being refilled by pharmacy". 9-7-16 Gabapentin (neuropathy) at 1:00 p.m., and Baclofen at 2:00 p.m., both omitted and the reason was given as "#3 Absent from home". There were no nursing notes for this day, and the LOA tracking note did not show the Resident as being signed out at all for that day. 9-13-16 Aspirin (long term use), calcium (supplement), multivitamin (supplement), effexor (major depression), fluticasone (seasonal rhinitis), hydrochlorothiazide (hypertension), lidocaine (knee pain), loratidine (seasonal rhinitis), norvasc (hypertension), and vitamin D (supplement), which was to be administered only once per day each according to physician's orders at 9:00 a.m. There were no nursing notes regarding the omission for this day, and the LOA tracking note showed the Resident checked out at 8:45 a.m., and again at 12:00 noon. This revealed that the 9:00 a.m. medications could have been administered before the Resident left at 8:45 a.m., or when the Resident returned which would have been before he checked back out at 12:00 noon., as these medications were only given once per day. Also, the Resident did not receive advair (COPD) at 9:00 a.m., colace (constipation) at 9:00 a.m., glucophage (diabetes) at 9:00 a.m., gabapentin (neuropathy) at 9:00 a.m., and situssin (cough) at 9:00 a.m., on 9-13-16, which were ordered multiple times per day, however, could have been administered at 8:45 a.m. before the Resident checked out.	F 309	4b. The QA nurse / designee will audit four charts (MARs) a week for three months for review of missed medications due to LOA to determine if other arrangements for medications can be made and discuss with MD as needed. 4c. The QA nurse / designee will audit four charts (MARs) a week of residents that have parameters to review for accurate medication administration. Nurses will be educated as needed. 4b. Results of the audits will be brought to the QA committee for three months to determine if further action is needed. 5a. 11/9/2016	

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9-17-16 Plavix (cerebrovascular disease) at 5:00 p.m., and gabapentin (neuropathy) at 5:00 p.m.. There were no nursing notes regarding the omission for this day, and the LOA tracking note showed the Resident checked out at 1:00 p.m., however does not indicate when the Resident returned. The plavix medication was a once per day medication, and the record indicated that all 9:00 p.m. medications were administered to this Resident, and this medication could have been administered when he returned.

9-18-16 Plavix (cerebrovascular disease) at 5:00 p.m., There were no nursing notes regarding the omission for this day, and the LOA tracking note showed the Resident checked out at 10:05 a.m., and the Resident returned at 7:45 p.m.. The plavix medication was a once per day medication, and the record indicated that all 9:00 p.m. medications were administered to this Resident, and this medication could have been administered when he returned.

9-20-16 Baclofen (muscle spasm) at 2:00 p.m., and gabapentin (neuropathy) at 1:00 p.m. Nursing notes regarding the omissions for this day revealed that the Resident left early and "returned after lunch". The LOA tracking note showed the Resident checked out at 9:20 a.m., however does not indicate the exact time the Resident returned. These 2 medications were ordered to be given after lunch, and were not. The Resident would not have received these medications again until 10:00 p.m. for the baclofen, and 5:00 p.m. for the gabapentin, and these medications could have been administered, "after lunch".

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F 309	Continued From page 20 9-24-16 Plavix (cerebrovascular disease) at 5:00 p.m., and gabapentin (neuropathy) at 5:00 p.m. Nursing notes regarding the omissions for this day revealed that the Resident "returned at 8:15 p.m.". The LOA tracking note showed the Resident checked out at 1:05 p.m.. The plavix was a once a day medication, and could have been administered upon the Resident's return to the facility. A thorough review of Resident #13's clinical record revealed no evidence he refused the medications. On 9-28-16 at 2:30 p.m., the Director of Nursing (DON) and Administrator were interviewed, and stated they would look into the discrepancy. The DON delivered a copy of the E-MAR, LOA Tracking record, and nursing notes. When interviewed the DON stated that the once per day medications could have been administered, and the doctor could be called to ok administration of one time per day meds to be given at a different time than what was originally planned, so that they would not be missed, she stated "it is what it is." The Director of Nursing (DON) and Administrator provided the facility policy which stated "Verify the medication is being administered at the proper time, prescribed dose, and by the correct route. Resolve any concerns about the medication with the provider, prescriber, and/or staff involved with the patient's care". The Administrator stated "Potter Perry" as their nursing standard. The administrator and DON (director of nursing) were informed of the failure of the staff to ensure medications were administered on numerous	F 309		

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days in September 2016, to Resident #13 at the end of day debriefings on 9-28-16, and 9-29-16.

2. For Resident #25, the facility staff failed to administer insulin per physician order.
Resident #25, an 80 year old, was admitted to the facility on 2/1/16. His diagnoses included diabetes, chronic kidney disease and hypertension.

Resident #25's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7/26/16. He was coded with a Brief Interview of Mental Status score of 12 indicating moderate cognitive impairment.

According to the clinical record and the September 2016 Medication Administration Record (MAR), Resident #25 had the following physician orders for insulin administration:
1. Lantus, inject 40 units one time a day, do not hold (9:00 a.m.)
2. Humulin R, inject 10 units one time a day (9:00 a.m.)
3. Humulin R, inject 16 units one time a day, HOLD if lunch intake is <25% (11:30 a.m.)
4. Humulin R, inject 16 units one time a day (4:30 p.m.)
5. Humulin R, inject per sliding scale three times per day (6:30 a.m., 11:30 a.m., 4:30 p.m.):
0-70= 0 units, notify MD (doctor)
71-90= 0 units, subtract 1 unit from the meal dose
91-150= 0 units, give along with scheduled meal dose
151-200= 2 units, give along with scheduled meal dose
201-250= 4 units, give along with scheduled

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meal dose
251-300= 6 units, give along with scheduled meal dose
301+= 8 units, call MD for blood glucose greater than 400

Issues with the administration of the insulin orders included:

A. Actual meal times and Humulin R sliding scale insulin administration times do not correspond.

Resident #25 ' s Humulin R sliding scale insulin order read " give along with scheduled meal dose " . According to the September 2016 MAR, Resident #25 was scheduled to receive Humulin R sliding scale insulin at 6:30 a.m., 11:30 a.m., 4:30 p.m. The facility served meals at the following times:
Breakfast= 7:45 a.m.
Lunch= 12:00 p.m.
Dinner= 5:15 p.m.
According to the administration times for the Humulin R sliding scale insulin order and the meal times, Resident #25 was receiving the sliding scale insulin before he was scheduled to eat his meals. The scheduled lunch dose of Humulin R included an extra parameter " HOLD if lunch intake is <25% " . The lunch dose of sliding scale Humulin R was scheduled before the lunch service. It is unclear if Resident #25 ' s lunch intake was being assessed prior to the administration of the 11:30 a.m. sliding scale Humulin R.

B. Administration times for Humulin R sliding scale did not correspond with the scheduled doses of Humulin R (per physician order).
The Humulin R sliding scale order included the

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F 309	Continued From page 23	F 309		

following " 71-90= 0 units, subtract 1 unit from the meal dose " . The " meal dose " in the sliding scale order is in reference to the scheduled doses of Humulin R administered at meal times.

Humulin R sliding scale was administered at 6:30 a.m., 11:30 a.m., and 4:30 p.m. The Humulin R scheduled doses were administered at 9:00 a.m., 11:30 a.m., and 4:30 p.m. The times of the scheduled Humulin R and the sliding scale Humulin R do not correspond. Sliding scale insulin administered at 6:30 a.m. did not have a corresponding scheduled meal dose of insulin. Because the sliding scale Humulin R insulin and the scheduled Humulin R insulin administration times did not correspond, the sliding scale parameters could not be implemented per physician order.

C. Insulin was not administered per physician order.

Sliding scale insulin administration and blood sugar readings were documented on the September 2016 MAR as follows:

9/28/16 (11:30 a.m.) 72 blood glucose level (millimeters/deciliter), 0 units

Licensed Practical Nurse C (LPN C) was the nurse who completed the documentation on the MAR on 9/28/16 (11:30 a.m.). According to the MAR, LPN C measured a blood sugar of 72 and gave 0 units of sliding scale coverage. According to the sliding scale, it was correct that 0 units of insulin be administered. But the sliding scale order also indicated that 1 unit of insulin should have been subtracted from the meal dose.

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	495393	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SITTER AND BARFOOT VETERANS CARE CENTER	1601 BROADROCK BLVD RICHMOND, VA 23224

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The " meal dose " referred to the scheduled meal dose of insulin, Humulin R inject 16 units one time a day.

According to the September 2016 MAR, the scheduled Humulin R 16 units was not administered. Instead of subtracting 1 unit of insulin from the meal dose (per sliding scale order), LPN C held the 16 units of Humulin R scheduled at 11:30 a.m.

LPN C was interviewed on 9/29/16 at 10:55 a.m. She was asked to review the sliding scale order, specifically "71-90= 0 units, subtract 1 unit the meal dose". LPN C was asked what " meal dose " meant. LPN C stated that the meal dose referred to the breakfast dose.

It was reviewed with LPN C that the blood sugar reading of 72 was measured at 11:30 a.m.. LPN C was asked if the " meal dose " at 11:30 a.m. referred to the scheduled lunch time dose of Humulin R. She again stated that the "meal dose" referred to the breakfast meal. When asked why she held the scheduled dose of Humulin R at 11:30 a.m., she stated she held the insulin because she felt the blood sugar was low.

On 9/29/16 at 11:15 a.m., Resident #25's sliding scale order was reviewed with the Director of Nursing (DON). The interview conducted with LPN C was also reviewed with the DON. The DON was notified that LPN C did not appear to understand the Humulin R sliding scale order and had not implemented the order per the parameters during the 9/28/16, 11:30 a.m. administration. It was also reviewed that sliding scale insulin to be administered at 6:30 a.m. did not have a corresponding meal dose. The DON

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agreed that the order needed to be clarified.

At the end of day meeting on 9/29/16, the insulin orders were reviewed with the DON and Administrator. No further information was provided.

3. The facility staff failed to administer Resident #24's Clonidine per the physician orders. Clonidine was administered when Resident #24's heart rate was less than or equal to 60, contrary to physician orders.

"Clonidine is used to treat hypertension. It lowers blood pressure by decreasing the levels of certain chemicals in your blood. Take Clonidine exactly as prescribed .." drugs.com
Resident #24 was admitted to the facility on 12/16/14 and readmitted after hospitalization on 6/22/15. His diagnoses included hypertension, gastroesophageal reflux disease, dementia, diabetes, depression, and anxiety.

Resident #24's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/29/16 was coded as a quarterly assessment. He was coded a BIMS (Brief Interview of Mental Status) score of 14, cognitively intact. Resident #24 was coded as requiring limited assistance of one staff member to perform his activities of daily living, with the exception of eating. For eating, he was coded as independent.

Resident #24 was observed 9/29/16 at 8:30 a.m. He was seated in the dining room and had just finished eating his breakfast.

At 9/29/16 at 9:00 a.m. a review of Resident

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#24's clinical record was conducted. The review revealed the following:
1. A care plan that read, "[Resident's Name] has a cardiac disease requiring the need for monitoring related to Coronary Artery Disease (CAD), Hypertension (HTN) and Hyperlipidemia." Interventions included, "Administer B/P (Blood Pressure) medications per parameters as ordered." The careplan was initiated on 12/02/2015.

2. A current signed physician's order initiated on 6/23/15 read, "CLONIDINE 0.1 mg (milligram). Give 1 tablet by mouth two times a day related to UNSPECIFIED HYPERTENSION. Hold for SBP (Systolic Blood Pressure) < (less than) or equal to 100 or HR (heart rate) < or equal to 60."

3. An August 2016 eMAR (electronic Medication Administration Record) revealed nurses' initials indicating the medication was administered daily with heart rate/ pulses documented. On the following days and times Resident #24's pulse was < or equal to 60 beats per minute:

"8/17/16 at 9 p.m. 60 beats per minute
8/28/16 at 9 p.m. 59 beats per minute
8/31/16 at 9 p.m. 60 beats per minute"

On 9/29/16 at 10:45 a.m., the ADON (Assistant Director of Nursing) was interviewed about Resident #24's Clonidine that had been administered when the measured pulses were equal to or below the physician ordered parameters to hold the medication. After reviewing Resident #24's clinical record, the ADON said he could find no documentation Clonidine was held on the days when Resident #24's pulses were less than or equal to 60 beats

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F 309	Continued From page 27 per minute. The ADON stated, "The expectation is for the nurses to follow the physician's orders. Review of the facility's Medication Administration policy revealed a procedure that read, "Prior to administration, the Nursing staff members administering the medication shall verify the medication is being administered at the proper time, in the prescribed dose, and by the correct route." Guidance for nursing practice for the administration of medications is included in Potter and Perry's, Fundamentals of Nursing 7th Edition, p 336, "The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients." On 9/29/16 at 12:15 p.m., the Administrator and DON (Director of Nursing) were informed of the failure of the staff to hold Clonidine when Resident #24's pulses were less than or equal to 60 beats per minute. No additional information was provided.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	F 323 1a. Resident #10 received new geri sleeves which were place d on resident 9/29/16. 1b. Resident #16 had his chair alarm replaced 9/28/16. Alarm interventions have been reviewed by the falls prevention committee and the chair alarm has since been discontinued.	

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by:
Based on observation, resident and staff interview, facility documentation and clinical record review, the facility staff failed to provide a safe environment for two residents (Resident #10 and Resident #16) in a survey sample of 30 residents.

1. Resident #10 did not have his protective (geri sleeves) in place.
2. For Resident # 16, the facility staff failed to apply a physician ordered fall preventive chair alarm.

The findings included:

Resident #10 was admitted to the facility on 12/29/15. Diagnoses for Resident #10 included but not limited to Parkinson's Disease, dementia and high blood pressure. Resident #10's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 9/20/16 coded Resident #10 with a BIMS (brief interview of mental status) of "15" out of a possible 15, or no cognitive impairment. In addition, the Minimum Data Set coded Resident #10 requiring limited assistance with eating and extensive assistance with dressing and toileting.

On 9/28/16 at 8:30 AM, Resident #10 was observed in his room. His alarm was on the bedside table. He was clean and well groomed. His arms were heavily bruised, and his skin was very thin. No skin protectors were in place.

On 9/28/16 at 11:20 AM, Resident #10 was observed in his room with the private sitter. He was not wearing skin protectors on his arms.

2a. All residents with protective devices for skin and chair alarms have the potential to be affected.

3a. Nursing staff will be in serviced on use of geri sleeves and alarms, to include checking for placement per orders and careplan.

3b. Unit managers will observe on daily rounds residents that have geri sleeves and alarms to ensure these devices are in place. Staff will be educated as needed.

4a. The QA nurse/designee will make rounds and audit eight residents a week for three months to ensure devices are in place.

4b. Results of the audit will be brought to the QA committee for three months to determine if further action is needed.

5a. 11/9/2016

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Resident #10 stated, "I like to wear the ones on my arms, I don't get scratched."

On 9/28/16 at 2:00 PM, an interview was conducted with CNA (certified nursing assistant) A. CNA (A) stated, "Night staff dresses him, I don't know about the skin protectors."

Review of the clinical record reveled a physician's order dated 6/22/16 and signed on the POS (physician order sheet) dated 8/7/16 for "Geri sleeves to forearms at all times every shift for fragile skin."

Review of the care plan dated 7/22/16 contained an entry for "geri sleeves." The care plan evidenced skin tears to right forearm on 3/7/16, and 6/22/16 a skin tear to the left forearm.

On 9/29/16 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings.

2. For Resident # 16, the facility staff failed to apply a physician ordered fall preventive chair alarm.

Resident #16 was admitted to the facility 4-11-16. Diagnoses included; Head injury with brain tumor and resection, seizures, anemia, depression, over active bladder, benign prostatic hypertrophy (BPH), and cognitive communication deficit, and had a history of falls at home with major injury, and falls at the facility with minor injury.

Resident #16's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7-12-16 was coded as a quarterly assessment. Resident #16 was coded as having short and long term memory deficits and as being

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moderately impaired in making own daily life decisions. Resident #16 was also coded as needing extensive to total assistance of one to two staff members for all activities of daily living. Resident #16 was coded frequently incontinent of bowel and always incontinent of bladder.

Resident #16's room was inspected on 9-28-16 at 8:45 a.m., an alarm box was noted hanging from the head board of the bed. No other alarms were found in the Resident room, and the Resident was not in the room.

Resident #16 was found and observed on 9-28-16 from 9:00 a.m. to 10:45 a.m.. The Resident was sitting in a wheelchair observing an activity in the main activity room adjacent to the nursing station desk, following breakfast. Resident #16 was wearing a sweat shirt, baseball cap, and pants. Resident #16 was completely visible through the floor to ceiling glass panels surrounding the room. The Resident had no visible alarm attached to the Resident.

At 10:45 a.m. the unit manager RN (G) was interviewed and asked if Resident #16 had his alarm on. RN G inspected the Resident and chair, and said i don't see one. RN G proceeded to the Resident room and retieved the Resident's alarm from his bed, and attached it to the Resident, and the wheel chair.

Review of Resident #16's physician order sheet revealed the following order,
dated "4-11-16 - Sensor alarm to bed and chair. Check for placement and functioning every shift." The alarm was to be applied to the Resident whether he was in bed or in the chair at all times according to RN G.

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F 323	Continued From page 31 Review of Resident #16's clinical record revealed a comprehensive care plan that had been most recently reviewed and revised on 6-26-16. Review of the comprehensive care plan revealed interventions for the application of Sensor alarm to bed and chair, check placement and functioning every shift, for "Risk of falls, and injury", and a history of falls at home and while in the facility. Review of the clinical record revealed nurses progress notes and the care plan indicating falls while in the facility on 5-22-16, and 6-26-16, with only minor injuries of skin tears, and bruising. A review of the nurse's notes did not reveal any refusals by Resident #16, to wear the sensor alarm. On 9-28-16 at approximately 4:30 p.m., the Director of nursing (DON) and Administrator were informed of the facility staff's failure to follow the physician orders for the application of the sensor alarm for Resident #16, the facility administration stated they had no further information to provide.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F 329 1a. Resident #7 attending physician was notified 10/13/16. Order clarified on the MAR to include space for monitoring of the pulse. 1b. Resident #24 attending physician was notified 10/13/16. No new orders given.	

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F 329	Continued From page 32 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review the facility staff failed for 2 residents (Resident #7 and #24) of 30 residents in the survey sample to ensure residents were free from unnecessary medications. 1. For Resident #7, facility staff failed to hold metoprolol (blood pressure medication) when the heart rate measured 60 or less. 2. For Resident #24, Clonidine was administered when Resident #24's heart rate was less than or equal to 60, contrary to physician orders. The finding included: 1. For Resident #7, facility staff failed to obtain a heart rate prior to the administration of metoprolol (blood pressure medication) and failed	F 329	2a. All residents receiving blood pressure medication have the potential to be affected. 3a. Licensed nurses will be educated on the following: following Physician orders (including review and following parameters), completing documentation following medication administration and on following the six rights of medication administration (right medication, right dose, right patient, right route, right time, right documentation). 3b. Nurses will be educated on how to input an order into the EHR (electronic health record) for a medication when parameters are given to include how often to take the blood pressure and / or pulse. 3c. Unit managers will review orders for blood pressure medications the next day to ensure orders have been entered correctly. Education will be given to the nurses as needed.	

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F 329	Continued From page 33 to hold the medication when the heart rate measured 60 or less per physician order. Resident #7, an 80 year old, was most recently admitted to the facility on 8/15/16. His diagnoses included hypertension, dementia, anxiety, dysphagia and left sided paralysis. His most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 9/12/16. He was coded with a Brief Interview of Mental Status score of 10 indicating moderate cognitive impairment and required extensive assistance with activities of daily living. Resident #7 was observed eating breakfast in the day room on 9/28/16. His assistive devices were in place. Resident #7's clinical record was reviewed. Included was a physician order dated 8/31/16 for Metoprolol. The order read Give 1 tablet by mouth two times a day hold for heart rate less than or equal to 60. The September 2016 Medication Administration Record (MAR) was reviewed. Heart rate (HR) reading and metoprolol were documented as follows: 9/2/16, 9:00 p.m., no HR, medication administered 9/4/16, 9:00 a.m., HR=60, medication administered 9/5/16, 9:00 a.m., HR=59, medication administered 9/11/16, 9:00 p.m., no HR, medication administered	F 329	4a. The QA nurse / designee will audit four charts a week for three months for residents receiving blood pressure medication (with parameters) to ensure the medication has been administered or held accordingly. 4b. Results of the audits will be brought to the QA committee for three months to determine if further action is needed. 5a. 11/9/2016	

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9/12/16, 9:00 p.m., HR=54, medication administered
9/21/16, 9:00 p.m., no HR, medication administered
9/22/16, 9:00 p.m., no HR, medication administered
9/23/16, 9:00 p.m., no HR, medication administered
9/24/16, 9:00 p.m., no HR, medication administered
9/25/16, 9:00 p.m., no HR, medication administered
9/26/16, 9:00 p.m., no HR, medication administered

On 8 occasions, metoprolol was administered without measuring the heart rate. On 3 occasions, metoprolol was administered when it should have been held. There were no adverse outcomes documented on the above dates.

The issue involving Resident #7's Metoprolol administration and parameters was reviewed with the Director of Nursing (DON) and Administrator at the end of day meeting on 9/28/16.
On 9/29/16, the DON provided Resident #7's nursing notes which included vital statistic information. Heart rates were not documented in the nursing notes for the dates in the above writing. No further information was provided.

2. For Resident #24, Clonidine was administered when Resident #24's heart rate was less than or equal to 60, contrary to physician orders.
"Clonidine is used to treat hypertension. It lowers blood pressure by decreasing the levels of certain chemicals in your blood. Take Clonidine exactly as prescribed .." drugs.com
Resident #24 was admitted to the facility on

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12/16/14 and readmitted after hospitalization on 6/22/15. His diagnoses included hypertension, gastroesophageal reflux disease, dementia, diabetes, depression, and anxiety.

Resident #24's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/29/16 was coded as a quarterly assessment. He was coded a BIMS (Brief Interview of Mental Status) score of 14, cognitively intact. Resident #24 was coded as requiring limited assistance of one staff member to perform his activities of daily living, with the exception of eating. For eating, he was coded as independent.

Resident #24 was observed 9/29/16 at 8:30 a.m. He was seated in the dining room and had just finished eating his breakfast.

At 9/29/16 at 9:00 a.m. a review of Resident #24's clinical record was conducted. The review revealed the following:
1. A care plan that read, "[Resident's Name] has a cardiac disease requiring the need for monitoring related to Coronary Artery Disease (CAD), Hypertension (HTN) and Hyperlipidemia." Interventions included, "Administer B/P (Blood Pressure) medications per parameters as ordered." The careplan was initiated on 12/02/2015.

2. A current signed physician's order initiated on 6/23/15 read, "CLONIDINE 0.1 mg (milligram). Give 1 tablet by mouth two times a day related to UNSPECIFIED HYPERTENSION. Hold for SBP (Systolic Blood Pressure) < (less than) or equal to 100 or HR (heart rate) < or equal to 60."

3. An August 2016 eMAR (electronic Medication

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495393	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SITTER AND BARFOOT VETERANS CARE CENTER	1601 BROADROCK BLVD RICHMOND, VA 23224

(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 329	Continued From page 36	F 329		

Administration Record) revealed nurses' initials indicating the medication was administered daily with heart rate/ pulses documented. On the following days and times Resident #24's pulse was < or equal to 60 beats per minute:

"8/17/16 at 9 p.m. 60 beats per minute
8/28/16 at 9 p.m. 59 beats per minute
8/31/16 at 9 p.m. 60 beats per minute"

On 9/29/16 at 10:45 a.m., the ADON (Assistant Director of Nursing) was interviewed about Resident #24's Clonidine that had been administered when the measured pulses were equal to or below the physician ordered parameters to hold the medication. After reviewing Resident #24's clinical record, the ADON said he could find no documentation Clonidine was held on the days when Resident #24's pulses were less than or equal to 60 beats per minute. The ADON stated, "The expectation is for the nurses to follow the physician's orders.

Review of the facility's Medication Administration policy revealed a procedure that read, "Prior to administration, the Nursing staff members administering the medication shall verify the medication is being administered at the proper time, in the prescribed dose, and by the correct route."

Guidance for nursing practice for the administration of medications is included in Potter and Perry's, Fundamentals of Nursing 7th Edition, p 336, "The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients."

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F 329	Continued From page 37 On 9/29/16 at 12:15 p.m., the Administrator and DON (Director of Nursing) were informed of the failure of the staff to hold Clonidine when Resident #24's pulses were less than or equal to 60 beats per minute. No additional information was provided.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #7) of 30 residents in the survey sample to ensure resident was free from significant medication errors. 1. For Resident #7, facility staff failed to hold metoprolol (blood pressure medication) when the heart rate measured 60 or less per physician order. The finding included: Resident #7, an 80 year old, was most recently admitted to the facility on 8/15/16. His diagnoses included hypertension, dementia, anxiety, dysphagia and left sided paralysis. His most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 9/12/16. He was coded with a Brief Interview of Mental Status score of 10 indicating moderate cognitive impairment and	F 333	F 333 1a. Resident # 7 attending physician was notified 10/13/16. Order was clarified. 2a. Residents that receive an antihypertensive medication has the potential to be affected. 3a. Licensed nurses will be educated on the following: following Physician orders (including review and following parameters), taking the pulse, completing documentation following medication administration and on following the six rights of medication administration (right medication, right dose, right patient, right route, right time, right documentation).	

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F 333	Continued From page 38 required extensive assistance with activities of daily living. Resident #7 was observed eating breakfast in the day room on 9/28/16. His assistive devices were in place. Resident #7's clinical record was reviewed. Included was a physician order dated 8/31/16 for Metoprolol. The order read Give 1 tablet by mouth two times a day hold for heart rate less than or equal to 60. The September 2016 Medication Administration Record (MAR) was reviewed. Heart rate (HR) reading and metoprolol were documented as follows: 9/4/16, 9:00 a.m., HR=60, medication administered 9/5/16, 9:00 a.m., HR=59, medication administered 9/12/16, 9:00 p.m., HR=54, medication administered On 3 occasions, metoprolol was administered when it should have been held according to the physician order. There were no adverse outcomes documented on the above dates. The issue involving Resident #7's Metoprolol administration and parameters was reviewed with the Director of Nursing (DON) and Administrator at the end of day meeting on 9/28/16. No further information was provided.	F 333	3b. Nurses will be educated on how to input an order into the EHR (electronic health record) for a medication when parameters are given to include how often to take the blood pressure and / or pulse. 3c. Unit managers will review orders for blood pressure medications the next day to ensure orders have been entered correctly. Education will be given to the nurses as needed. 4a. The QA nurse / designee will audit four charts a week for three months for residents receiving blood pressure medication (with parameters) to ensure the medication has been administered per orders. 4b. Results of the audits will be brought to the QA committee for three months to determine if further action is needed. 5a. 11/9/2016	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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

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F 371	Continued From page 39 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to prepare and serve food in a sanitary manner. 1. Hair restraints were not stored at the entrance of the kitchen, they were stored above one of the prep tables. 2. Prepped food was stored in the steamer, not turned on or cooking. 3. Nested wet serving pans were on the storage rack. 4. The dishwasher was not reaching manufacturer's temperature during the rinse cycle. 5. Staff on one of the dining room kitchens washed their hands and turned the faucet off with their bare hand as opposed to a paper towel. The findings included: 1. Hair restraints were not stored at the entrance	F 371	1a. The hair restraints have been relocated to the entrance to the kitchen. 1b. The food in the steamer was discarded and not used. 1c. The pots and pans were rewashed before use. 1d. The back-up process of using strips for testing was implemented. The manufacturer came to inspect the machine 9/28/2016. The Eco Lab representative performed dish machine temperature checks the morning of 9/28/16. 1e. The staff member was educated on correct hand hygiene and the facilities policy. 2a. All residents have the potential to be affected. 3a. Dietary staff will be educated on the following: keeping hair restraints at the entrance to the kitchen, prepping and storage of food, how to take food temperatures, use of the steamer and storage of food, cleaning and storage of pots and pans, hand hygiene, and temperature / function of the dishwasher.	F 371

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F 371	Continued From page 40 of the kitchen, they were stored above one of the prep tables. The initial tour of the facility's kitchen began 9/27/16 at 2:42 p.m. Other D, the dietary manager, came to the door to the kitchen. As no hair restraints were noted to be near the door, the dietary manager stated the hair restraints were always kept on the top shelf of one of the prep tables. The prep table was all the way into the kitchen and parallel to the ovens and stoves. Other D stated the hair restraints were always stored on the top of the prep table and that as no food preparation was occurring, that should have been alright. 2. Prepped food was stored in the steamer, not turned on or cooking. Approximately 2:51 p.m., the steamer was observed. The steamer was turned off. In the top section of the steamer was observed two large pans of broccoli in water with what appeared to margarine or butter on the top. The dietary manager had stated the broccoli was for dinner and that dinner would not be served until 5:15-5:30 p.m. When asked, Other D said the supervisor must have already prepped the broccoli for dinner and the broccoli should not have sitting in the steamer uncooked. Other D said the food to be cooked should be put in the steamer in preparation for the meal and should not be in the steamer more than an hour before the meal. Located in the bottom half of the steamer was observed: large pan of peas, large pan carrots,	F 371	3b. Temperatures will be taken on the dish machine for each meal. The Dietary manager / designee will be notified if the temperature does not reach 180 degrees. 3c. Dish machine will have monthly checks by the Eco Lab representative. 4a. The Dietitian / designee will make rounds in the kitchen weekly for three months to observe for placement of hair restraints, inspection of the steamer in regards to food storage, pots and pans storage after washing, temperature log for the dish machine. 4b. The Dietitian will report to the QA committee for three months as to findings on rounds to determine if further action is necessary. 5a. 11/9/2016	

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F 371	Continued From page 41	F 371		

pan with hot dogs, pan with gravy, pan with 2 chicken breasts, pan cream soup, pan tomato soup, pan with hamburger patties, pan of mixed vegetables, and pan with ground turkey. All of the pans had plastic wrap over them and in some of the pans the plastic wrap was covered with water. While the pans felt a little warm, the steamer was not turned on.

Other E, the supervisor, stated he had prepped the broccoli and put it in the steamer. Other E stated one of the cooks had called in and he (Other E) was busy and trying to get the dinner meal prepared. Other E also stated all of the pans in the bottom of the steamer had been left from lunch. Other E stated he was planning on serving the tomato and cream soup with the dinner meal. Other E said he knew he should not have the food in the steamer that long, not turned on.

3. Nested wet serving pans were on the storage rack.

Located on the storage rack were the serving pans for the steam tables. Other D stated the pans were used for cooking and serving on the steam table. On the top of the stacks of pans were observed four 4 inch steam table pans,two 2 inch steam table pans, and three 4 inch half steam table pans that were wet and dripping when separated from the stack.

Other D stated the pans had been used at lunch and should not have been nested wet.

4. The dishwasher was not reaching manufacturer's temperature during the rinse cycle.

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F 371	Continued From page 42	F 371		

The dishwasher was observed at approximately 3:10 p.m. Three staff members were processing the dirty dishes. Upon approaching the dishwasher, the temperature gauges were observed with one gauge for the wash cycle and one for the rinse cycle. The next new load was observed with the rinse temperature gauge never going beyond 160 degrees Fahrenheit during the rinse cycle. Two more loads were observed with the rinse water temperature never going beyond 172 degrees Fahrenheit during the rinse cycle. Other F, the staff member removing the dishes after they left the dishwasher stated there was a sanitizer that also went into the rinse cycle. Other F pointed to the "rinse aid" container located on top of the machine.

Other D said she would have to get maintenance to check on the machine. Other D stated the dishwasher was a high temperature machine and no sanitizer went into the machine. Other D said the temperature should get to at least 180 degrees Fahrenheit during the rinse cycle. A sign was posted above the gauges that indicated the wash temperature should be at least 160 degree Fahrenheit and the rinse temperature should be 180 degrees Fahrenheit,

Other D turned the dishwasher off and on and when the next load ran, the rinse temperature rose to 182 degrees Fahrenheit. Other D ran a load with a test strip that indicated the food surface temperature of the plate was 160 degrees. For that load, the rinse temperature was noted to be 180 degree Fahrenheit.

Other D indicated she used the strips to check. If the food surface temperature of the plate was

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F 371	Continued From page 43	F 371		

160 degrees Fahrenheit, the water had to get to 180 degrees Fahrenheit. Other D also directed the staff to rewash the dishes during the time the rinse temperature did not get to 180 degree Fahrenheit.

On 9/28/16 at 10:15 a.m., the kitchen staff were observed washing breakfast dishes. The first two loads that were run, the rinse temperature gauge did not change from 152 degrees Fahrenheit. The wash cycle was noted to get to 160 and 164 degrees Fahrenheit. Other D turned the dishwasher off and on again and the next two loads that were run revealed the rinse temperature was at 182 and 180 degrees Fahrenheit.

The staff in the kitchen again indicated the "rinse aid" was a sanitizer product. Other D stated the maintenance staff and the company that provided the washing products had checked the dishwasher, stating the problem was "lime deposits" preventing the gauge from reading correctly.

Other D provided the MSDS (material safety data sheets) for the rinse aid, "Solid Brilliance." The sheets indicated the product was a rinse aid.

Other C, was contacted by phone 9/28/16 at 2:10 p.m. Other C, employee of the company that supplies the rinse aid, stated rinse aid was not a sanitizer and had no sanitizing properties. Other C stated the rinse aid assisted with preventing spotting and quicker drying. Other C also said the facility had a high temperature dishwasher with no added sanitizer.

5. Staff on one of the dining room kitchens

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washed their hands and turned the faucet off with their hand as opposed to a paper towel.

The dining room for the B/C hall on the Richmond unit was observed 9/28/16 at 7:52 a.m. At approximately 8:10 p.m., the dietary staff member (Other B) came to the unit, pushing a cart. Other B was wearing plastic gloves when she entered the unit. Other B removed her gloves and washed her hands, turning the water off with her bare hand. Other B donned another pair of gloves.

Other B removed the plastic wrap from the tops of the steam table serving pans. Other B took the temperatures of all of the food, vegetable omelet, sausage, potatoes, oatmeal, fried egg, muffin, bacon. While Other B used an alcohol pad to clean the thermometer, she used the same pad for all the foods.

Other B removed her gloves and washed her hands, turning the faucet off with her bare hand. Other B donned a new pair of gloves. Other B prepared several bowls of oatmeal. Other B removed her gloves, washing her hands. Other B turned the faucet off with her bare hands.

Other B began to serve the Residents their breakfast, with floor staff coming to the steam table to retrieve the plates.

When asked, Other B stated she should turn the water off with a paper towel, not her bare hand, 9/28/16 at 8:32 a.m.

Review of the facility's policy "Hand Hygiene" included:

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F 371	Continued From page 45 1. HAND WASHING When hands are visibly dirty or contaminated with proteinaceous material, are visibly soiled with blood or other body fluids, and in the case of a resident with a spore-forming organism (e.g., C. Difficile-clostridium difficile), perform hand hygiene with either a non-antimicrobial soap and water or an antimicrobial soap and water. A. Turn on water to a comfortable warm temperature. B. Moisten hands with soap and water and make a heavy lather. C. Wash well under running water for a minimum of 15 seconds, using a rotary motion and friction. D. Rinse hands well under running water. E. Dry hands with a clean paper towel. Use the paper towel to turn off the faucet, then discard." The administrator and ADON (assistant director of nursing) were informed of the failure of the staff to ensure hair restraints were readily accessible prior to entering the food preparation area, ensure food was not sitting in the steamer not cooking or being held at an appropriate temperature, ensure pans were not wet and nested, ensure the dishwasher was rinsing dishes at an appropriate temperature, and ensure staff performed hand hygiene correctly, 9/28/16 at 3:30 p.m.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 46 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure medications and biologicals were stored	F 431	F 431 1a. The thermometer was replaced in the refrigerator and the temperature was then 38 degrees. The medication (Prevnar and vial of PPD) were discarded. 1b. Both vials of insulin on the Bayside cart were discarded. 1c. The vial of insulin on the Richmond cart was discarded. 2a. All residents have the potential to be affected. 3a. Nurses will be educated on the labeling/dating/ storage / expiration dates / discarding of refrigerated medications (to also include insulin). 3b. Licensed nurses will be educated on checking refrigerator temps and completing a maintenance request form if the temperature is out of range (36-46 degrees). 3c. The Unit manager will check the med room refrigerator temperature log weekly for any discrepancies. A maintenance repair ticket will be completed if indicated. Staff will be educated as needed.	

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F 431	Continued From page 47 per manufacturer's recommendation on three of four units. 1. The medication refrigerator temperature on Blue Ridge was observed to be 28 degrees Fahrenheit, one vial of PPD (purified protein derivative -tuberculin testing) and 4 Prevnar syringes (pneumococcal vaccine) were in the refrigerator. The manufacturer's recommendations were for both was to be stored at 36-46 degrees Fahrenheit; and 2. One vial of unopened, unaccessed Lantus insulin and one vial of Novolog insulin dated as having been accessed 8/23/16 were stored in the Bayside C hall cart.; 3. One vial of unopened unaccessed vial of Novolog insulin was stored in the C/d hall medication cart on the Richmond unit. The findings included: 1. The medication refrigerator temperature on Blue Ridge was observed to be 28 degrees Fahrenheit, with one vial of PPD (purified protein derivative -tuberculin testing) and 4 Prevnar pre-filled syringes (pneumococcal vaccine) stored in the refrigerator. The manufacturer's recommendations were for both to be stored at 36-46 degrees Fahrenheit. The medication room on Blue Ridge unit was observed 9/27/16 at 3:35 p.m. Upon opening the medication refrigerator, the temperature within was 28 degrees Fahrenheit. Located within the refrigerator was one vial of PPD and four pre-filled syringes of Prevnar,	F 431	3d. The Unit manager / designee will check med carts weekly for expired medications for the labeling and expiration of medications. Discrepancies will be corrected immediately. Nurses will be educated as needed. 4a. The Pharmacy tech/designee will check/audit one med room and one med cart per unit twice a month for three months. 4b. Results of the audits will be brought to the QA committee for three months to determine if further action is needed. 5a. 11/9/2016	

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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
F 431	Continued From page 48	F 431		

Review of the manufacturer's recommendations for both biologicals revealed the biologicals should be stored at 36 to 46 degrees Fahrenheit.

RN (registered nurse) G stated the night shift was responsible for checking and logging the medication refrigerator.

2. One vial of unopened, unaccessed Lantus insulin and one vial of Novolog insulin dated as having been accessed 8/23/16 were stored in the Bayside C hall cart.

The C hall medication cart was observed on Bayside unit, 9/27/16 at 3:48 p.m. Located within the medication cart was noted one unopened unaccessed vial of Lantus insulin. LPN (licensed practical nurse) K stated the vial had been delivered to the facility 9/27/16 by the date on the box. LPN K stated she could not say when the vial was put in the medication cart but she thought it would have been on 9/27/16. LPN K stated insulin should be stored in the refrigerator until opened for Resident use.

Within the medication cart was also one vial of Novolog insulin dated as having been opened and accessed 8/23/16. LPN K stated insulin was only good for 28 days after opening.

Review of the manufacturer's instructions for Lantus insulin revealed at www.lantus.com:

"Storage conditions are summarized in the following table:
10 ml (milliliter) vial Not in use (unopened) Refrigerated 36-46 degrees Fahrenheit Use until expiration date

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	495393	A. BUILDING _____ B. WING _____	C 09/29/2016

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10 ml vial Room Temperature 28 days"

Once the vial was not refrigerated, the vial of insulin would only be good for 28 days. Without dating, the staff would have no idea of when the insulin was not stored in the refrigerator and when the 28 day interval would be expired.

The manufacturer's recommendations for Novolog insulin at www.novolog.com:

"Novolog 10 ml vial Not in use/unopened/room temperature 28 days

Not in use/unopened/ Refrigerated until manufacturer's expiration date

In use opened Refrigerated/room temperature 28 days"

Review of the facility's guidance for storage of insulins included Lantus and Novolog insulin were able to be administered 28 days after opening. No guidance was provided for insulins not refrigerated prior to accessing.

3. One vial of unopened unaccessed vial of Novolog insulin was stored in the C/D hall medication cart on the Richmond unit.

The medication cart for C/D hall of the Richmond unit, 9/27/16 at 4:10 p.m. One vial of unopened unaccessed Novolog insulin was observed within the medication cart. LPN A stated the vial was delivered to the facility on 9/26/16 and should have been stored in the refrigerator and not in the medication cart. LPN A stated the vial would only be good for 28 days as it had not been refrigerated.

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F 431	Continued From page 50 The administrator and ADON (assistant director of nursing) were informed of the failure of the staff to ensure the temperature of the medication refrigerator was an appropriate temperature for storing Prevnar and PPD, and failed to ensure the staff stored insulin per manufacturer's instructions, 9/28/16 at 3:30 p.m.	F 431		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, 1 of 6 staff failed to verbalize understanding of Fire response strategies, and response to weather emergencies. The findings included: On 9-28-14 at 11:30 p.m., a telephone interview was conducted with the RN supervisor (RN A) who could not complete the interview independently. After a short conversation about what the surveyor would be asking in the interview, the surveyor commenced with the formal questions. RN A was asked, if a fire was found in a Resident's room what would she do. RN A	F 518	F 518 1a. The staff member was re-educated on emergency preparedness processes for the facility. 2a. All residents have the potential to be affected. 3a. Staff will be re-educated on facility emergency preparedness processes. 3b. Staff will be educated on facility emergency preparedness processes during orientation and annually thereafter. 4a. The QA Nurse/designee will randomly ask four staff members a week for three months questions related to emergency preparedness. Staff will be educated as needed. 5a. 11/9/2016	

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responded she would get the resident out and try to put out the fire. She was asked if they used an acronym to remind staff of the steps to take to respond to a fire emergency, and she stated yes, it was PASS. She was asked what those letters stood for, and she responded point and sweep at the fire. She was asked if that was in reference to the fire extinguisher, she stated yes. RN A was then asked again what would she do if she found a fire in a resident's room. RN A responded that she would get the fire doors closed. When asked if the fire doors closed on their own, she responded yes. When asked how the rest of the facility would know there was a fire, she stated she would page overhead and let every one know. At no time, even with cueing did she respond with Rescue, Alarm, Contain, and Extinguish (RACE), and seemed not to be able to verbalize that pull boxes must be initiated to sound the alarms and automatically close the fire doors after rescuing the Resident. When asked what would she do to keep the residents safe during natural disasters such as tornado warnings, or hurricanes, RN A responded she would keep the resident's safe, and that it sounded as if there was a tornado in the parking lot "right now". She was asked what was she doing to keep the residents safe, and she gave no response. It was noted that during the interview there were active and strong thunder storms in the area. At this point, the RN supervisor was then asked to place a direct care staff member on the phone to complete the interview, and Certified Nurse Aide (CNA-B) answered the phone and introduced herself without difficulty. After a short conversation about what the surveyor would be asking in the interview, CNA B was able to complete the interview with good knowledge of procedures

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evidenced in the interview.

Facility policy & procedure on fire and emergencies stated clearly and effectively the required training received by staff members, and this was evidenced by CNA B, however, RN A was unable to verbalize knowledge of the facility policies.

On 9-29-16 at 10:00 a.m., an interview was conducted with the Director of Nursing (DON), and Administrator. They stated that all staff received training/information regarding facility's emergency procedures at least annually.

On 9-29-16 at 10:00 a.m., and again at the end of day debrief at 11:00 a.m., the Administrator and DON were notified of the 11:00 p.m. to 7:00 a.m. (RN A) staff member's inability to show knowledge of facility emergency procedures.

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