STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495079	A. BUILDING _____ B. WING _____	C 01/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE CENTER LUCY CORR	6800 LUCY CORR BLVD CHESTERFIELD, VA 23832

(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 1/4/17 through 1/6/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 216 certified bed facility was 200 at the time of the survey. The survey sample consisted of 27 current Resident reviews (Residents #1 through #27) and 4 closed record reviews (Residents #28 through #31).	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 225		2/7/17

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

Electronically Signed | 01/24/2017

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F 225	Continued From page 1 (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and	F 225		

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F 225	Continued From page 2 if the alleged violation is verified appropriate corrective action must be taken. 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 report an injury of unknown origin to the state agency (SA) for one Resident (Resident #18) in a survey sample of 31 Residents. Resident #18 was noted to have a bruise to her left ring finger on 11/24/16 that was subsequently diagnosed as being fractured. The injury was not reported to the SA at the Office of Licensure and Certification. The findings included: Resident #18, a female, was admitted to the facility 8/10/16. Her diagnoses included constipation, unspecified dementia with behavioral disturbances, atrial fibrillation, dysphagia, peripheral vascular disease, seizures, anemia, hyperlipidemia, hypertension, cerebral infarction, and celiac disease. Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/16/16 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was also coded as requiring extensive to total assistance of one staff member to perform her activities of daily living. Resident #18 was coded as having no behaviors including self injurious behaviors during the look back period.	F 225	F 225 Corrective Action(s): Resident # 18□s bruise and fracture to her left ring finger noted on November 24, 2016 have resolved. Resident #18□s attending Physician and her responsible party was notified that the facility failed to report an injury of unknown origin to the state agency. A Facility reported incident was completed and submitted to the required state agencies. Identification of Deficient Practice & Corrective Action(s): All residents with injury of unknown origin may have potentially been affected. A 100% review of all Risk management Incident and Accident Reports for the previous 30 days will be reviewed to identify residents at risk. Any/all negative findings of reportable occurrences identified will result in a report to the State agency and an internal investigation with the outcomes reported to the appropriate State agencies, attending physician and responsible parties. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. The Administrative and Nursing staff will be educated by the Administrator and/or designee on the Abuse Reporting Policy, including completion of Incident/Accident	

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F 225	Continued From page 3 Resident #18 was observed 1/5/17 at 9:55 p.m. She was sitting in her wheelchair in the dining room. A personal alarm was in place on the back of her wheelchair. She was appropriately dressed. She was sitting at the dining table with her hands resting on the table. Review of Resident #18's clinical record revealed on 11/24/16 while the CNA (certified nursing assistant) was assisting her with dressing, the CNA noticed Resident #18's "left ring finger" was bruised and discolored. The CNA notified the nurse "immediately." The physician and responsible Party were notified on 11/24/16. Resident #18 left the facility with her family on 11/24/16 (Thanksgiving day) and according to the nursing notes had no complaint of the finger at that time. By 11/25/16 at 11:28 a.m., the physician was informed of Resident #18's discoloration of her left ring finger and the physician ordered an xray and doppler study to be performed. The x-ray was obtained and revealed: "12/25/16 There is age-determinated fracture through the shaft of the proximal phalanx of the 5th finger. There are mild degenerative changes and osteopenia. Slight soft tissue swelling is seen." The physician was notified and an order was written to send Resident #18 to the ER for evaluation of her fractured finger. Review of the clinical record including nursing notes, MDS, and other interdisciplinary notes revealed no evidence that Resident #18 had hit	F 225	investigations and timely submission to the appropriate state agencies. Monitoring: The Administrator is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The QA Audit will be conduct weekly by the DON and/or designee for completion of investigations and proper reporting. All negative findings will result in an internal investigation with the outcomes reported to the appropriate State agencies, attending physician and responsible parties. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	

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F 225	Continued From page 4	F 225		

her hand or had any behavioral issues of self-injurious behavior prior to identification of her fractured finger.

Review of the facility's investigation revealed a statement was obtained from the CNA that initially identified the bruising to Resident #18's finger. The statement was dated as having been obtained at some point in time on 11/24/16. The statement included "The resident is very active with her hands. She is usually grabbing, pulling, touching just about anything at her reach." There was no indication as to when the statement was obtained on 11/24/16. The rest of the statements were dated as having been obtained 11/25/16. Review of the "Incident & Accident Report" indicated the writer felt the bruise to her finger was due to "Resident is restless."

When interviewed regarding the failure of the facility staff to report an injury of unknown origin (fractured left finger) to the SA, the administrator stated 1/5/17 at 4:55 p.m., the investigation revealed the injury was caused by Resident #18 banging her hands on her table and other environmental objects. When asked for documentation regarding Resident #18 banging her hands, the administrator stated it was determined during the investigation. The administrator stated the staff stated they had observed her banging her hands when interviewed after the bruise and fracture were found.

Review of the facility's policy entitled "Abuse Policy, Reporting and Investigations" included:

"7) Reporting

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F 225	Continued From page 5 *The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.... *(name of facility) will immediately report all alleged violations involving neglect, abuse, including injuries of unknown source, mistreatment and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator or his or her designee of the facility." The administrator and ADON (assistant director of nursing) were informed of the failure of the staff to report an injury of unknown origin to the SA, 1/6/16 at 11:42 a.m.	F 225		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 241		2/7/17

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F 241	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide a dignified living experience for one Resident (Resident #1) in a survey sample of 31 Residents. For Resident #1, the term "diapers" was utilized in the physician's orders and progress notes instead of "incontinent brief." The findings included: Resident #1, a female, was admitted to the facility 9/15/14. Her diagnoses included major depressive disorder, cancer of colon, chronic obstructive pulmonary disease, hypercholesterolemia, enuresis, dysphagia, dementia with Lewy body, cellulitis, Vitamin D deficiency, anxiety, glaucoma, hypertension, arteriosclerotic cardiovascular disease, and muscle weakness. Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/21/16 was coded as a quarterly assessment. Resident #1 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was coded as requiring extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating, she was coded as needing standby by assistance. Review of Resident #1's clinical record revealed she had developed an abrasion to her left lip. The clinician assessed Resident #1 and entered	F 241	F 241 Corrective Action(s): Resident #1□s Responsible party was notified that a physician referred to her use of incontinence products as Diapers in the written record. The physician who authored the progress note and order was notified of the failure to provide a dignified living experience. Identification of Deficient Practice & Corrective Action(s): All other residents who utilize incontinence products for their incontinence needs may have potentially been affected. The DON and/or designee will do a 100% review of all current physician orders to verify all residents with orders related to continence products have no inappropriate verbiage that would be negative to their dignity. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. The Administrator and/or Medical Director will educate the Attending physicians on the policy and procedure regarding resident rights and dignity. The DON and/or designee will educate all staff on the policy and procedure regarding resident rights and dignity. The interdisciplinary team will review clinical documentation for all residents on an ongoing basis and report any verbiage that would be negative to a resident□s dignity to the Administrator.	

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F 241	Continued From page 7 in the progress notes: "small abrasion on L (left) hip due to being thin & rubbing from adult diapers. Start barrier cream." One of the nursing staff created a verbal order that included: "12/6/16 Barrier cream to hips to prevent irritation from diapers daily." When interviewed 1/6/17 at end of day conference, the administrator had no response to the staff, both floor staff and clinician, utilizing the term "diapers" to refer to Resident #1's use of incontinent briefs. "Fundamentals of Nursing, 7 th Edition, Potter-Perry, p. 475," provides guidance, "A sense of dignity includes a person's positive self-regard, an ability to invest in and gain strength from one's own meaning in life, feeling valued by others, and how one is treated by caregivers. Nurses promote a client's self esteem and dignity by respecting him or her as a whole person with feelings, accomplishments, and passions independent of the illness experience...When caring for a client's bodily functions, show patience and respect, especially after the client becomes dependent." The administrator and ADON (assistant director of nursing) were informed of the failure of the staff to ensure the use of Resident #1's incontinent briefs were documented in a dignified manner, 1/6/17 at 11 a.m.	F 241	Monitoring: The DON is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The DON and/or designee will complete the audit tool weekly coinciding with the MDS/CP calendar. Any/all negative findings from the audit will be reported to the Risk management Committee for review.. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	
F 246 SS=D	REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES CFR(s): 483.10(e)(3) 483.10(e) Respect and Dignity. The resident has	F 246		2/7/17

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F 246	Continued From page 8 a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility documentation review, facility staff failed, for one resident (Resident #4) of the survey sample of 31 residents, to ensure that her food was within reach. For Resident #4, the facility staff failed to ensure that her food was within reach. The Findings included: Resident #4 was an 86 year old who was admitted to the facility on 3/23/16. Resident #4's diagnoses included Osteoporosis, Major Depressive Disorder, Gastroesophageal Reflux Disease, and Dysphasia. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 12/30/16, coded Resident #4 as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. In addition, Resident #4 requires 1 staff person to set up her meals within reach. On 1/5/17 at 9:05 A.M. an observation was conducted of Resident #4 in her room. Her bed was in its lowest position close to the floor.	F 246	F 246 Corrective Action(s): Resident #4□s Responsible party and physician were notified that her food was not in reach on January 5, 2017 at 9:05 a.m. The direct care staff working with Resident #4 were in serviced that day on accommodations when assisting with meals for this resident. Identification of Deficient Practice & Corrective Action(s): All other residents who received assistance with meal delivery and setup may have potentially been affected. The DON and/or designee will do a 100% review of all resident□s dining preferences to ensure that all residents have reasonable accommodations during meals. Any/all findings that may not meet the needs of the resident will be corrected and a facility Incident and Accident report form will be completed. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. The DON and/or designee will educate all staff on the	

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F 246	Continued From page 9 Resident #4 was sitting on the side of her bed with her legs hanging over the side of the bed, but not touching the floor. Her tray table was in a high position, causing her food to be out of reach. The tray table was at her eye level, instead of being near her waist level. Resident #4 stated, "They serve my breakfast late. They come in and say they'll be right back to help with my food and wash me. Resident #4 stated that breakfast was brought up at about 8:30 A.M. Resident #4's breakfast hadn't been eaten. During the time the surveyor was in the room, the facility staff still had not come in to place Resident #4's food within her reach. The surveyor did not observe any staff present on Resident #4's hallway. On 1/5/17 a review was conducted of Resident #4's clinical record. Her weight had remained stable for the previous few months. The record contained the following signed Physicians Order, "9/21/16. Diet Mechanical Soft, per patient's preference." On 1/6/17 at 11:15 A.M. an interview was conducted with the facility Administrator (Administration A). She stated, "We inserviced the staff. They assisted her out of bed to eat today. Her tray will be adjusted when she prefers to eat in bed. Her legs will not hang over the bed, the staff were trained in safety."	F 246	policy and procedure regarding resident rights and accommodation of needs. The interdisciplinary team will review clinical documentation for all residents on an ongoing basis and report any changes in needs or preferences related to meal service. Monitoring: The DON is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The DON and/or designee will complete the audit tool weekly coinciding with the MDS/CP calendar. Any/all negative findings from the audit will be reported to the Risk management Committee for review. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development	F 280		2/7/17

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F 280	Continued From page 10	F 280		

and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

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F 280	Continued From page 11 (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to review and	F 280	F280 Corrective Action(s):	

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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 280	Continued From page 12 revise the comprehensive plan of care for one Resident (Resident #1) in a survey sample of 31 Residents. The use of bed and chair alarms were discontinued and the facility staff failed to revise the plan of care after they were discontinued. The findings included: Resident #1, a female, was admitted to the facility 9/15/14. Her diagnoses included major depressive disorder, cancer of colon, chronic obstructive pulmonary disease, hypercholesterolemia, enuresis, dysphagia, dementia with Lewy body, cellulitis, Vitamin D deficiency, anxiety, glaucoma, hypertension, arteriosclerotic cardiovascular disease, and muscle weakness. Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/21/16 was coded as a quarterly assessment. Resident #1 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was coded as requiring extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating, she was coded as needing standby by assistance. She was coded as having had no falls since the previous assessment. Resident #1 was observed 1/4/17 at 3:06 p.m. Two staff members transferred her from her bed to her wheelchair with a mechanical lift. No bed alarm was noted under Resident #1 at the time of her transfer, nor was a chair alarm in place once	F 280	Resident # 1 was re-evaluated and does not require the use of a bed and chair alarm. The orders reflect this in the record and care plan. Identification of Deficient Practice & Corrective Action(s): All residents with safety alarms may have been potentially affected. A 100% review of current care plans will be conducted by the DON and/or designee to ensure that each resident has a comprehensive care plan with specific and measurable goals and appropriate interventions to meet the resident□s individual medical needs. Any/all negative findings will be reported to the DON for corrective action. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. The assessment process will continue to be utilized as the primary tool for developing comprehensive care plans. The MDS coordinators and Interdisciplinary care planning team will be educated on the policy and procedure for care planning by the DON. Monitoring: The DON, MDS coordinators and interdisciplinary Team will be responsible for verifying the resident specific care plans. The QA program includes an audit tool for monitoring compliance. The QA Audit tool, Care plan audit will be utilized to conduct a random 10% audit of current	

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F 280	Continued From page 13 she was transferred to her wheelchair. Resident#1 was also observed out of bed and in her wheelchair, 1/5/17 at 8:30 a.m. and 1/6/16 at 8:24 a.m. She was sitting in the dining room with a half tray table in place over her lap. No chair alarm was noted attached to the wheelchair at any of the observations. Review of Resident #1 clinical record revealed she had been assessed and determined to be at risk for falls with a care plan revised 9/7/16. Documentation revealed Resident #1 had a history of previous falls, and the interdisciplinary team had developed a plan 9/28/16 to prevent injury from falls that included "Bed Alarm check function" and "Chair alarm check function." A chair or bed alarm was a device that was attached to Resident #1's bed or chair that would alert the staff if Resident #1 attempted to rise unassisted. Review of Resident #1's clinical record revealed no physician's order that included for a bed or chair alarm to be utilized for Resident #1. LPN (licensed practical nurse) D, the unit manager, observed Resident #1 1/6/17 at 8:24 a.m. She stated she did not observe any personal alarm and would review the clinical record. LPN D did state that if a personal alarm, either bed or chair, was being utilized for Resident #1, a physician's order should be present. The administrator stated 1/6/17 at 11 a.m., the alarms had been discontinued for Resident #1, and a physician's order was presented that included, "9/19/16 dc (discontinue) bed and chair alarms no longer needed." The administrator	F 280	care plans weekly for twelve weeks to verify that the comprehensive care plans are completed timely, accurately, and are resident specific. Any/all findings will be reported to the DON and the MDS coordinator will make corrections at the time of discovery. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	

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was unaware why the care plan interventions were added to the care plan 9/28/16 when they had been discontinued 9/16/16.

The administrator stated the MDS staff were responsible for updating and revising the care plan.

Guidance for the creation of an individualized care plan is provided by "Fundamentals of Nursing 7th Edition, Potter-Perry, p. 268:

In any health care setting a nurse is responsible for providing a written plan of care for all clients. The plan of care sometimes takes several forms...In hospitals and community-based settings, the client often receives care from more than one nurse, physician, or allied health professional. A written nursing care plan makes possible the coordination of nursing care, subspecialty consultations, and scheduling of diagnostic tests...You design a written plan to direct clinical nursing care and to decrease the risk of incomplete, incorrect, or inaccurate care. As the client's problems and status change, so does the plan. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used in evaluation. The written plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of nursing care by listing specific nursing interventions needed to achieve the goals of care. All nurses who care for a given client will then carry out these nursing interventions throughout a given day during a client's length of stay. A correctly formulated nursing care plan makes it easier to continue care from one nurse to another."

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F 280	Continued From page 15 The administrator and ADON (assistant director of nursing) were informed of the failure of the staff to review and revise the comprehensive plan of care for Resident #1 after bed and chair alarms were discontinued, 1/6/17 at 11 a.m.	F 280		
F 281 SS=E	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review and in the course of a complaint investigation, the facility staff failed to follow the professional standards of nursing regarding medications and treatments for 8 Residents (# 14, # 28, # 16, # 18, # 9, # 7, # 6 and # 19) in a survey sample of 31 residents. 1. For Resident # 14, the facility staff failed to ensure the medications and treatments were documented as having been administered. 2. For Resident # 28, the facility staff failed to clarify an order to remove the PICC (Peripherally Inserted Central Catheter) line after Antibiotic completed on 11/25/2015. 3. For Resident #16, the facility staff failed to ensure medications and treatments were	F 281	F281 Corrective Action(s): The attending physician and responsible parties for Residents # 14, 28, 16, 18, 9, 7, 6 and #19 have been notified of the omission of documentation for medication and/or treatment administration. A facility Incident and Accident report form was completed for these incidents. Identification of Deficient Practice & Corrective Action(s): All other residents receiving medications may have been potentially affected. The DON and/or designee will do a 100% review all resident medication and treatment records to ensure all orders are transcribed correctly and medications and	2/7/17

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F 281	Continued From page 16 documented as having been administered; 4. For Resident #18, the facility staff failed to ensure medications and treatments were documented as having been administered; 5. For Resident #9, the facility staff failed to assure that multiple medications were administered and documented as having been given. 6. For Resident #7, the facility staff failed to assure that multiple medications and treatments were administered and charted as having been given. 7. For Resident #6, the facility staff failed to document the administration of medications and treatments on several occasions during August, 2016 through November, 2016. 8. For Resident #19, the facility staff failed to document the administration of medications and treatments on several occasions during August, 2016 through November, 2016. Findings included: 1. For Resident # 14, the facility staff failed to ensure the medications and treatments were documented as having been administered. Resident #14, a female, was admitted to the facility 6/23/16. Her diagnoses included but were not limited to: Diabetes, Hypertension, Spinal Stenosis, Hypothyroidism, Dry Eye Syndrome, Seborrheic Dermatitis, Arthopathy and Atherosclerotic Heart Disease.	F 281	treatment supplies are available. Any/all negative findings will be communicated to the DON for corrective action. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. Licensed Nursing staff will be educated by the DON and/or designee on the policy and procedure for the proper administration and delivery of medications and treatments. Monitoring: The DON is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The DON and/or designee will conduct random weekly medication pass and treatment observations audits to monitor compliance. Any/all negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	

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F 281	Continued From page 17 Resident #14's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/10/15 was coded as a Quarterly assessment. Resident #14 was coded as having no long and short term memory deficits and was able to make her own daily life decisions. Resident #14 was also coded as needing supervision to total assistance of one staff member to perform her activities of daily living. Review of Resident #16's clinical record revealed no evidence the following medications or treatments were administered per physician's orders: Aspirin 81 milligrams 1 tablet by mouth daily for Atherosclerotic heart disease: 10/28/2016 at 9 AM Ibuprofen 800 milligrams 1 tablet by mouth at bedtime for Chronic Pain Syndrome: 10/3/2016 at 9 PM Icy Hot Balm Extra Strength Ointment 7.6-29% Apply to Right hip topically at bedtime: 10/3/2016 at 9 PM , 10/17/2016 at 9 PM Lisinopril 2.5 mg 1 tablet every 12 hours for hypertension: 8/6/15 at 10 a.m. Lyrica 150 milligrams 1 capsule every night (pain): 10/17/2016 at 9 PM Metformin 500 milligrams give 1.5 tablets by mouth daily for Diabetes: 10/28/2016 at 7:30 AM Norvasc 5 milligrams 1 tablet by mouth daily for hypertension: 10/28/2016 at 9 AM	F 281		

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F 281	Continued From page 18 Simvastatin 10 milligrams 1 tablet by mouth at bedtime for Atherosclerotic Heart Disease: 10/3/2016 at 9 PM, 10/17/2016 at 9 PM Synthroid 25 micrograms 1 tablet by mouth daily for Hypothyroidism: 10/28/2016 at 6 AM Tylenol Extra Strength 500 milligrams 1 tablet by mouth at bedtime for pain: 10/3/2016 at 9 PM , 10/17/2016 at 9 PM Preser Vision AREDS 2 capsules (Multiple Vitamins-Minerals) 1 capsule by mouth two times a day: 10/28/2016 at 9 AM Artificial Tears Solution 1.4 % instill 1 drop in both eyes four times a day for Dry Eye Syndrome: 10/3/2016 at 9 PM , 10/17/2016 at 9 PM, 10/28/2016 at 9 AM , 10/28/2016 at 12 PM Review of the October 2016 Treatment Administration Record revealed missing documentation of: Cleanse Skin Tear to left forearm with Normal Saline, Apply Xerorm, dry dressing, wrap with Kling, and secure with tape daily until healed: 10/25/2016, 10/27/2016 and 10/28/2016.(all on day shift) Geri Sleeves to bilateral arms: 10/4/2016 at 9 AM , 10/27/2016 at 9 AM, 10/28/2016 at 9 AM Review of the progress notes revealed no documentation was available to indicate Resident #14 either refused the medications and treatments or was not present at the facility for	F 281		

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the days and times indicated. Valid physicians' orders were evident for the medications and treatments not documented as having been administered.

The Administrator, Acting DON, and Chief Executive Officer were informed of the failure of the staff to ensure medications and treatments were documented as having been administered during the end of day debriefing on 1/5/2017 at 5:00 PM. The Administrator stated Lippincott as the professional nursing standard followed by the facility. The Administrator stated the expectation was for nurses to document the administration of medications at the time of administration.

The facility policy entitled Medication Administration General Guidelines for the Administration of Medications, Effective June 2014 on Page 2 of 3 read,
"10. Nurse records the medication administered on the Medication Administration Record. If the resident refuses the mediation, he/she indicates the failure to administer on the MAR and in the Nurses' Notes and includes reason."

Guidance given from Potter and Perry, Fundamentals of Nursing, Eighth Edition, page 305 read: "Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Therefore you need to assess all orders; if you find one to be erroneous or harmful, further clarification from the health care provider is necessary." Page 584 read: "To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights:

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F 281	Continued From page 20 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation." No further information was provided. 2. For Resident # 28, the facility staff failed to clarify an order to remove the PICC (Peripherally Inserted Central Catheter) line after Antibiotic completed on 11/25/2015. Resident # 28 was admitted to the facility originally on 11/11/2014 and readmitted on 4/16/2015, 11/18/2015 and 12/22/2015 with diagnoses to include but not limited to: Alzheimer's Disease, Dementia, Glaucoma, Atrial Fibrillation, Kidney Failure, Hypertension, Anxiety, Heart Failure, Urinary Retention, Bacteremia and Pain. The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 12/29/2015. The MDS coded Resident # 28 with moderate cognitive impairment; Resident # 28 required extensive to total assistance of one to two staff persons with activities of daily living; Resident # 28 was coded as always incontinent of bowel and an indwelling catheter for bladder. Review of the closed clinical record for Resident # 28 was conducted on 1/6/2017 at 9:30 AM.	F 281		

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F 281	Continued From page 21 Review of the Hospital Discharge Note dated 11/18/2015 revealed orders to "remove the PICC line after antibiotic completed 11/25" Review of the Infectious Disease Outpatient Antibiotic Orders showed orders for the PICC line for Indication: Urosepsis Proteus Bacteremia. The orders were for 2. weekly labs; 7. PICC line: "Pull PICC Line at the end of IV antibiotic course" and "May send patient to Interventional Radiology for line evaluation or replacement as needed". There were 4 options for orders from the physician regarding the PICC line. There were two options not checked: one option was "Do not pull PICC line at end of therapy and maintain through:_____." The other option was "Send patient to Interventional Radiology for line removal at end of course." On the bottom of the form Under Antibiotics was written "Cefepime 1 gram IV (intravenously) every 8 hours through 11/25/2015." Review of the Admission orders for Readmission to the facility on 11/18/2015 revealed orders handwritten on a Physician's order sheet for 11/18/15-11/30/15. On Page 2 under the list of handwritten medications, the medication order in the second box read: Cefepime 1 gram in 100 milliliters of normal saline every 8 hours via PICC line, Stop date 11/25/15. On the right hand side of page 3, the area was checked for IV (Intravenous) ABT (Antibiotic Therapy) for diagnosis of Urosepsis with a stop date of 11/25/2015. The readmission orders were signed by the physician on 11/21/2015. On 1/6/2017 at 11:25 AM, an interview was	F 281		

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conducted with the facility Administrator (Admin A) who stated the facility had an order to discontinue the PICC line by the attending physician but also because the resident was being followed by Infectious Disease doctors, the facility wanted to be sure the resident was cleared by Infectious Disease before removing the PICC line. The Administrator stated the PICC line was removed on 12/2/2015 after the resident was cleared.

On 1/6/2017 at 1:30 PM, the Administrator (Admin A) stated she was positive that there was an order to remove the PICC line because she was the nurse who removed the PICC line. The Administrator (Admin A) was the Director of Nursing of the facility at the time Resident # 28 was in the facility. At approximately 1:45 PM, Admin A presented a copy of the Nurses Note dated 12/2/2015 at 4:10 PM which stated "Residents PICC line discontinued by writer without difficulty." Admin A also presented a copy of the orders from Infectious Disease physicians which ordered to "Pull PICC Line at the end of IV antibiotic course" and "May send patient to Interventional Radiology for line evaluation or replacement as needed". Under Antibiotics was written "Cefepime 1 gram IV (intravenously) every 8 hours through 11/25/2015."

During the end of day debriefing on 1/6/2017, the facility Administrator, Acting Director of Nursing and Chief Executive Officer were informed of the findings.
No further information was provided.
3. For Resident #16, the facility staff failed to ensure treatments were documented as having been administered.

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Resident #16, a female, was initially admitted to the facility 3/15/05. Her diagnoses included vascular dementia, vertebral compression fracture, Bell's palsy, dysthrymic disorder, Parkinson's disease, arthropathy, osteoporosis, dysphagia, and hypertension.

Resident #16's most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/18/16 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #16 was coded as needing extensive assistance of one staff member to perform her activities of daily living with the exception of eating. For eating she was coded as needing setup assistance only.

Review of Resident #16's clinical record revealed no evidence the following treatments were documented as having been administered:

Nystatin Powder apply under both breasts twice daily until area healed: 10/28/16 at 8 a.m., 10/29/16 8 a.m., 11/19/16 8 a.m., 11/20/16 8 a.m., 12/6/16 5 p.m.

Apply protective barrier (zinc) cream to buttocks and peri area for protection every shift: 10/16/16 day shift, 10/22/16 day shift, 10/23/16 day shift, 10/23/16 evening shift, 10/24/16 night shift, 10/28/16 day shift, 10/29/16 day shift, 11/20/16 day shift, 12/2/16 night shift, 12/5/16 night shift, 12/6/16 evening shift, 12/8/16 evening shift, 12/12/16 evening shift, 12/17/16 evening shift, 12/23/16 evening shift

Apply skin prep barrier wipe to left forearm every shift: 10/16/16 day shift, 10/22/16 day shift,

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10/23/16 day shift, 10/23/16 evening shift, 10/24/16 night shift, 10/28/16 day shift, 10/29/16 day shift, 11/20/16 day shift, 12/2/16 night shift, 12/5/16 night shift, 12/6/16 evening shift, 12/8/16 evening shift, 12/12/16 evening shift, 12/17/16 evening shift, 12/23/16 evening shift

Chair alarm check placement and function ever shift: 10/16/16 day shift, 10/22/16 day shift, 10/23/16 day shift, 10/23/16 evening shift, 10/24/16 night shift, 10/28/16 day shift, 10/29/16 day shift, 11/9/16 day shift

Dycem to wheelchair (a device to prevent Resident #16 from slipping from her chair) every shift: 10/16/16 day shift, 10/22/16 day shift, 10/23/16 day shift, 10/23/16 evening shift, 10/24/16 night shift, 10/28/16 day shift, 10/29/16 day shift, 11/20/16 day shift, 12/2/16 night shift, 12/5/16 night shift, 12/6/16 evening shift, 12/8/16 evening shift, 12/12/16 evening shift, 12/17/16 evening shift, 12/23/16 evening shift

Encourage non skid socks every shift: 10/3/16 day shift

Skin prep right foot 3rd, 4th, and 5th toe every shift: 10/16/16 day shift, 10/22/16 day shift, 10/23/16 day shift, 10/23/16 evening shift, 10/24/16 night shift, 10/28/16 day shift, 10/29/16 day shift; 11/20/16 day shift, 12/2/16 night shift, 12/5/16 night shift, 12/6/16 evening shift

Cleanse right lower calf skin tear with NS (normal saline), apply xerofoam, cover with dry dressing every evening shift until healed: 12/17/16, 12/23/16

Valid physician's orders were evident for the

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treatments in question. Additionally, review of Resident #16's clinical record revealed no evidence she was not at the facility nor that she refused the treatments in question.

Review of the facility's policy entitled "General Guidelines For The Administration Of Medications" included:

"10. Nurse record the medication administered on the Medication Administration Record. If the resident refuses the medication, he/she indicates the failure to administer on the MAR (medication administration record) and in the Nurses' Notes and includes reason."

Guidance for nursing standards for the administration of medication and treatments was 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 ADON (assistant director of nursing) were informed of the failure of the staff to ensure treatments were documented as

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having been administered for Resident #16, 1/6/17 at 11 a.m. The administrator stated the expectation was for nursing staff to administer medications as ordered by the physician and to document when the medications and treatments are administered.

4. For Resident #18, the facility staff failed to ensure treatments were documented as having been administered.

Resident #18, a female, was admitted to the facility 8/10/16. Her diagnoses included constipation, unspecified dementia with behavioral disturbances, atrial fibrillation, dysphagia, peripheral vascular disease, seizures, anemia, hyperlipidemia, hypertension, cerebral infarction, and celiac disease.

Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/16/16 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was also coded as requiring extensive to total assistance of one staff member to perform her activities of daily living.

Review of Resident #18's clinical record revealed no evidence the following treatments were administered:

Dycem to wheelchair, check every shift for placement: 12/23/16 night shift

Floor mat when in bed check placement every shift: 12/3/16 day shift, 12/23/16 night shift

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Hipster for protection, check placement every shift: 12/3/16 day shift, 12/23/16 night shift

Cleanse left anterior shin with normal saline, apply xerofoam gauze and cover with dry dressing and secure with paper tape every day shift: 12/6/16

Apply protective barrier cream with zinc to bilateral buttocks every shift: 12/3/16 day shift, 12/23/16 night shift

Bed alarm; check placement and function every shift: 12/3/16 day shift, 12/23/16 night shift

Chair alarm; check placement and function every shift: 12/3/16 day shift, 12/23/16 night shift

A thorough review of Resident #18's clinical record revealed no evidence she was not at the facility, nor that she had refused the treatments in question. A valid physician's order was in place for the treatments in question.

The administrator and ADON were informed of the failure of the staff to ensure treatment were documented as having been administered for Resident #18, 1/6/17 at 11 a.m.

5. For Resident #9, the facility staff failed to assure that multiple medications were administered and documented as having been given.
Resident #9, a 90 year old female, was admitted to the facility on 5/19/2011 and readmitted on 10/3/2016. Her diagnoses included Alzheimer's, hypertension, hypothyroidism, depression, Vitamin D deficiency, cognitive communication defect, left femur fracture, and generalized

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weakness.
Resident #9's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/23/2016 was coded as a 14 day assessment. She had a BIMS (Brief Interview of Mental Status) score of 6/15 which indicated severe cognitive defect. She required moderate assistance of one person for her activities of daily living, and was coded as being always continent of bowel and occasionally incontinent of bladder.
A review of the clinical record was conducted on 1/5/2017 at 10:30 AM and it revealed multiple medications not documented as having been administered on the times and dates as follows:
Acetaminophen Tablet 500 mg (milligram) one tablet oral at bedtime-11/10/2016 9:00 PM, 11/22/2016 9:00 PM, 11/25/2016 9:00 PM, 12/01/2016 9:00 PM.
Donepezil 10 mg Tablet one tablet oral at bedtime-11/10/2016 9:00 PM, 11/22/2016 9:00 PM, 11/25/2016 9:00 PM, 12/6/2016 9:00 PM.
Levothyroxine Sodium Tablet 88 mcg (microgram) one tablet oral daily-11/17/2016 6:00 AM, 11/23/2016 6:00 AM, 11/26/2016 6:00 AM, 11/27/2016 6:00 AM.
Melatonin Tablet 3 mg one tablet oral at bedtime-11/10/2016 9:00 PM, 11/22/2016 9:00 PM, 11/25/2016 9:00 PM, 12/6/2016 9:00 PM.
Magnesium Hydroxide 30 ml (milliliter)-30 ml oral at bedtime 11/10/2016 9:00 PM, 11/22/2016 9:00 PM, 11/25/2016 9:00 PM, 12/6/2016 9:00 PM.
Metoprolol 25 mg one tablet oral at bedtime-11/10/2016 9:00 PM, 11/22/2016 9:00 PM, 11/25/2016 9:00 PM, 12/6/2016 9:00 PM.
Namenda 10 mg oral two times daily-12/6/2016 6:00 PM.
An interview was conducted 1/6/2017 at 11:00 AM with Administration A, Facility Administrator who stated that the expectation is that all

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medications and treatments are given per physician orders and charted accordingly.
A review of the facility document, "General Guidelines for the Administration of Medications" stated "Nurse records the medication administered on the Medication Administration Record. The facility staff will provide safe and accurate medication administration to the residents."
Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter and Perry, p705: Professional standards such as the American Nurses Association, Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medication administration. 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 "

On 1/6/2017 at 3:00 PM the administration was informed of the findings.

6. For Resident #7, the facility staff failed to assure that multiple medications and treatments were administered and charted as having been given.
Resident #7, a 90 year old female, was admitted to the facility on 8/26/2016. Her diagnoses included dementia, depression, coronary artery

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disease, cognitive deficit, diabetes, psychosis, stroke, hypokalemia, and edema.
Resident #7's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/3/2016 was coded a quarterly assessment. She was rated as having moderate cognitive impairment via staff assessment. She required extensive assistance of 2+ persons for her activities of daily living and was always incontinent of bowel and bladder.
A review of the clinical record was conducted on 1/4/2017 at 2:15 PM revealed multiple medications and treatments not documented as having been administered on the dates and times as follows:
Bed alarm check placement and function every shift-9/30/2016 day shift, 10/28/2016 day shift, 12/11/2016 evening shift, 12/23/2016 night shift
Chair alarm check placement and function every shift- 9/30/2016 day shift.
Elevate head of bed when eating/drinking every shift-9/30/2016 day shift, 10/28/2016 day shift, 12/11/2016 evening shift, 12/23/2016 night shift
Floor mat while in bed. Check placement every shift-9/30/2016 day shift, 10/28/2016 day shift
Weight bearing as tolerated every shift-9/30/2016 day shift, 10/28/2016 day shift.
Check temperature daily x 3 days start 10/29/2016-10/30/2016 not charted.
½ side rails up for self-turning and positioning every shift-10/28/2016 day shift, 12/11/2016 evening shift, 12/23/2016 night shift
Wheelchair alarm check function and placement every shift-10/28/2016 day shift
Ecotrin low strength aspirin 81 mg (milligram) daily oral-10/28/2016 8:00 AM
Felodipine 5 mg daily oral-10/28/2016 8:00 AM
Glimepride 1 mg oral daily-10/228/2016 8:00 AM
Miralax oral daily-12/28/2016 8:00 AM

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Potassium Chloride 10 MEQ (milleqivalant) oral daily-10/28/2016 8:00 AM
Zoloft 25 mg oral daily-10/28/2016 8:00 AM
Quetiapine 25 mg ½ tablet oral 2x daily-10/28/2016 8:00 AM
An interview was conducted 1/6/2017 at 11:00 AM with Administration A, Facility Administrator who stated that the expectation is that all medication and treatments are given per physician orders and charted accordingly.
A review of the facility document "General Guidelines for the Administration of Medications" stated "Nurse records the medication administered on the Medication Administration Record. The facility staff will provide safe and accurate medication administration to the residents."
Guidance for nursing practice for following physicians' orders was included in Potter and Perry-"Fundamentals of Nursing 7th Edition page 336", which stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."
On 1/6/2017 at 3:00 PM the administration was informed of the findings.
7. For Resident #6, the facility staff failed to document the administration of medications and treatments on several occasions during August, 2016 through November, 2016.

Resident #6 was an 88 year old who was admitted to the facility on 12/10/15. Resident #6's diagnoses included Hereditary and Idiopathic Neuropathies, Pain, Constipation, Hypothyroidism and Gastroesophageal Reflux Disease.

The Minimum Data Set was a Quarterly Assessment with an Assessment Reference Date

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of 11/25/16, coded Resident #6 as having a Brief Interview of Mental Status Score of 5, indicating severe cognitive impairment.

On 1/7/17 a review was conducted of Resident #6's clinical record, revealing the following medications and treatments that were not documented as having been administered per signed physician orders:

1. Ensure Plus 10 ml by mouth three times daily for prophylaxis 8/6/16 at 9 P.M.

2. Fall mat for safety check placement every shift 9/6/16 - 9/9/16 at evening shift.

3. Levothroid Tablet 50 MCG. tablet by mouth once daily 11/17/16 and 11/27/16 at 6:00 A.M. for Hypothyroidism

Resident #6's care plan read, "1/21/16. High risk for falls related to confusion, gait/balance problems, history of fall. Administer medications as ordered."

8. For Resident #19, the facility staff failed to document the administration of medications and treatments on several occasions during August, 2016 through November, 2016.

Resident #19 was an 81 year old who was admitted to the facility on 1/23/15. Resident #19's diagnoses included Osteoarthis, Aortic Aneurysm with pain, Major Depressive Disorder, and Pain, Unspecified.

On 1/7/17 a review was conducted of Resident

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#19's
clinical record, revealing the following medications and treatments that were not documented as having been administered per signed physician orders:

1. Clonidine HCl Tablet 0.3 mg. Give 1 tablet daily by mouth three times a day related to Major Depressive Disorder. 12/22/16 at 9:00 P.M. 12/23/16 a 2:00 P.M.

2. Gabapentin Capsule. Give 200 mg. by mouth at bedtime for neuropathy pain. 12/22/16 at 9:00 P.M.

Resident #19's care plan read, "8/9/16. Pain medication therapy related to disease process has diagnosis of osteoarthritis with joint pains and Aortic Aneurysm with pain. Administer medications as ordered."

On 1/7/17 a review was conducted of facility documentation, revealing the General Guidelines for the Administration of Medications dated June 2014. It read, "Nurse records the medication administered on the Medication Administration Record (MAR). If the resident refuses the medication, he/she indicates the failure to administer on the MAR and in the Nurse's Notes and includes reason."

On 1/6/17 at 11:20 A.M. in the conference room the Administrator (Administration A) was notified of the findings. The Administrator was asked about the facility's expectation regarding documentation of medication administration. The Administrator stated that the facility expected for the medication to be administrated as ordered, and if they didn't give it for some reason they

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F 281	Continued From page 34 should document it on the MAR and follow-up with the physician for further instructions."	F 281		
F 309 SS=D	COMPLAINT DEFICIENCY PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that	F 309		2/7/17

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F 309	Continued From page 35 residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation the facility staff failed to provide care and services to achieve the highest possible well-being for 4 residents (#7, #18, #14 and #28) in a survey sample of 31 residents. 1. For Resident #7, the facility staff failed to obtain blood glucose levels and administer insulin if needed per physician's order. 2. For Resident #18, the facility staff failed to administer Keppra (a seizure medication) per physician's order. 3. For Resident # 14, the facility staff failed to ensure the medications Lisinopril and Norvasc were administered as ordered by the physician. 4. For Resident # 28, the facility staff failed to remove the PICC line after completion of a course of antibiotics on 11/25/2015 as ordered by the Physician. Findings included: 1. For Resident #7, the facility staff failed to obtain blood glucose levels and administer insulin if needed per physician's order. Resident #7, a 90 year old female, was admitted to the facility on 8/26/2016. Her diagnoses included dementia, depression, coronary artery disease, cognitive deficit, diabetes, psychosis, stroke, hypokalemia and edema. Resident #7's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/3/2016 was coded a quarterly assessment.	F 309	F309 Corrective Action(s): The attending physician and responsible parties for Residents # 7 have been notified of the omission of documentation for obtaining blood glucose levels and the administration of insulin. A facility Incident and Accident report was completed for this incident. The attending physician and responsible parties for Residents #18 have been notified of the omission of documentation for the medication, Keppra, administration. A facility Incident and Accident report form was completed for this incident. The attending physician and responsible parties for Residents # 14 have been notified of the omission of documentation of Lisinopril and Norvasc s administration. A facility Incident and Accident report was completed for this incident. Resident #28 is no longer a resident in the facility. The PICC had been discontinued December 2, 2015.	

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F 309	Continued From page 36 She was rated as having moderate cognitive impairment via staff assessment. She required extensive assistance of 2+ persons for her activities of daily living and was always incontinent of bowel and bladder. A review of the clinical record was conducted on 1/4/2017 at 2:15 PM revealed a physician order dated 9/24/2016 stating: "Accuchecks (blood glucose checks) AC (before meals) and QHS (at bedtime). Notify MD if blood glucose < (less than) 60 or > (greater than) 350" (Milligrams per deciliter). A review of the MAR (Medication Administration Record) for October 2016 revealed multiple occasions where blood glucose checks were not completed per the order on the following dates and times: 10/15/2016 9:00 PM, 10/16/2016 11:00 AM, 10/28/2016 7:30 AM, 10/28/2016 11:00 AM An interview was conducted 1/6/2016 at 11:00 AM with Administration A, Facility Administrator who stated that the expectation is that all medication and treatments are given per physician orders and charted accordingly. A review of the facility document "General Guidelines for the Administration of Medications" stated "Nurse records the medication administered on the Medication Administration Record. The facility staff will provide safe and accurate medication administration to the residents." Guidance for nursing practice for following physicians' orders was included in Potter and Perry-"Fundamentals of Nursing 7th Edition page 336" which read, "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients." On 1/6/2017 at 3:00 PM the administration was	F 309	Identification of Deficient Practice & Corrective Action(s): All other residents receiving insulin and have physician orders to obtain blood glucose levels may have been potentially affected. All other residents receiving medications may have been potentially affected. All other residents who have a PICC line may have been potentially affected. The DON and/or designee will do a 100% review all resident medication and treatment records to ensure all orders are transcribed correctly and medications and treatment supplies are available. Any/all negative findings will be communicated to the DON for corrective action. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. Licensed Nursing staff will be educated by the DON and/or designee on the policy and procedure for following physician orders including obtain blood glucose levels, proper administration and delivery of medications and treatments and discontinuing PICC lines. Monitoring: The DON is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The DON and/or designee will conduct random weekly medication pass and treatment observations audits to monitor compliance. Any/all negative findings will	

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F 309	Continued From page 37 informed of the findings. 2. For Resident #18, the facility staff failed to ensure Keppra (a seizure medication) was administered per physician's order. Resident #18, a female, was admitted to the facility 8/10/16. Her diagnoses included constipation, unspecified dementia with behavioral disturbances, atrial fibrillation, dysphagia, peripheral vascular disease, seizures, anemia, hyperlipidemia, hypertension, cerebral infarction, and celiac disease. Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/16/16 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was also coded as requiring extensive to total assistance of one staff member to perform her activities of daily living. Resident #18 was coded as having no behaviors including self injurious behaviors during the look back period. Resident #18 was observed 1/5/17 at 9:55 p.m. She was sitting in her wheelchair in the dining room. A personal alarm was in place on the back of her wheelchair. She was appropriately dressed. Review of Resident #18's clinical record revealed an entry in the eMAR (electronic medical record) and nursing notes that indicated "Keppra tablet 500 mg (milligram) 1 tablet twice daily for seizures" was not administered on 12/18/16 at 5 p.m. A "9" was entered on the eMAR that referred the reader to the nursing notes for clarification as to why Keppra 500 mg was not	F 309	be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	

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administered. An entry in the nursing notes indicated Keppra 500 mg was not available for administration. A valid physician's order was evident for Keppra 500 mg to be administered to Resident #18 twice daily.
Keppra is a medication utilized to treat seizure disorder. Keppra was the brand name for Levetiracetam. Guidance for the administration of Keppra/Levetiracetam was provided at www.medlineplus.gov:
"Levetiracetam is used in combination with other medications to treat certain types of seizures in adults and children with epilepsy. Levetiracetam is in a class of medications called anticonvulsants. It works by decreasing abnormal excitement in the brain.
How should this medicine be used?
Levetiracetam comes as a solution (liquid), an immediate-release tablet, an extended-release (long-acting) tablet, and as a tablet for suspension (a tablet to take with liquid) to take by mouth. The solution, immediate-release tablet, and tablet for suspension are usually taken twice a day, once in the morning and once at night, with or without food. The extended-release tablets are usually taken once daily with or without food. Try to take levetiracetam at around the same time(s) every day. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take levetiracetam exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor.
Levetiracetam controls epilepsy but does not cure it. Continue to take levetiracetam even if you feel well. Do not stop taking levetiracetam without talking to your doctor, even if you experience side effects such as unusual changes in behavior or mood. If you suddenly stop taking levetiracetam,

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your seizures may become worse. Your doctor will probably decrease your dose gradually."
Review of the emergency supply of medications at the facility revealed that Levetiracetam 500 mg was available for the staff to administer.
When interviewed, the administrator stated 1/5/16 at 4:55 p.m. Keppra/Levetiracetam was available in the emergency supply of medications and she was unaware of why the staff did not administer the medication 12/18/16 at 5 p.m.
The administrator and ADON (assistant director of nursing) were informed of the failure of the staff to administer Keppra 500 mg to Resident #18 on 12/18/16 at 5 p.m., 1/6/17
3. For Resident # 14, the facility staff failed to ensure the medications Lisinopril and Norvasc were administered as ordered by the physician.

Resident #14, a female, was admitted to the facility 6/23/16. Her diagnoses included but were not limited to: Diabetes, Hypertension, Spinal Stenosis, Hypothyroidism, Dry Eye Syndrome, Seborrheic Dermatitis, Arthopathy and Atherosclerotic Heart Disease.

Resident #14's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/10/16 was coded as a Quarterly assessment. Resident #14 was coded as having no long and short term memory deficits and was able to make her own daily life decisions. Resident #14 was also coded as needing supervision to total assistance of one staff members to perform her activities of daily living.

Review of Resident #16's clinical record revealed no evidence the following medications were administered per physician's orders:

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Review of the October 2016 Medication Administration Record (MAR) revealed documentation of the number 9 and a nurse's initials for two medications:
Lisinopril 20 milligrams give 1 tablet by mouth one time a day for Hypertension on 10/27/2016 at 9 AM and 10/31/2016 at 9 AM

Norvasc 5 milligrams 1 tablet by mouth daily for hypertension:on 10/27/2016 at 9 AM and 10/31/2016 at 9 AM

Review of the MAR under Chart Codes revealed the number 9= Other/See Progress Notes.
Review of the Progress Notes revealed documentation of "Type: Orders-Administration Note, Note Text: Not Available. 10/27/2016 at 11:49 AM, 10/31/2016 at 9:17 AM.

Review of the medications available in the STAT Box (Emergency Drugs) revealed the medications were available in the facility but still were not given. Among the medications available in the STAT box were: Lisinopril 10 milligrams and Amlodipine 5 milligrams.

During the end of day debriefing on 1/5/2017, the facility Administrator stated the facility used Lippincott for Professional Nursing Guidance.

Guidance given from Potter and Perry, Fundamentals of Nursing, Eighth Edition, page 305 read: "Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Therefore you need to assess all orders; if you find one to be erroneous or harmful, further clarification from the health care provider is necessary."

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4. For Resident # 28, the facility staff failed to remove the PICC line after completion of a course of antibiotics on 11/25/2015 as ordered by the Physician.

Resident # 28 was admitted to the facility originally on 11/11/2014 and readmitted on 4/16/2015, 11/18/2015 and 12/22/2015 with diagnoses to include but not limited to: Alzheimer's Disease, Dementia, Glaucoma, Atrial Fibrillation, Kidney Failure, Hypertension, Anxiety, Heart Failure, Urinary Retention, Bacteremia and Pain.

The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 12/29/2015. The MDS coded Resident # 28 with moderate cognitive impairment; Resident # 28 required extensive to total assistance of one to two staff persons with activities of daily living; Resident # 28 was coded as always incontinent of bowel and an indwelling catheter for bladder.

Review of the closed clinical record for Resident # 28 was conducted on 1/6/2017 at 9:30 AM.

Review of the Hospital Discharge Note dated 11/18/2015 revealed orders to "remove the PICC line after antibiotic completed 11/25."

Review of the Infectious Disease Outpatient Antibiotic Orders showed orders for the PICC line for Indication: Urosepsis Proteus Bacteremia. The orders were for 2. weekly labs; 7. PICC line: "Pull PICC Line at the end of IV antibiotic course" and "May send patient to Interventional Radiology for line evaluation or replacement as needed".

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F 309	Continued From page 42 There were 4 options for orders from the physician regarding the PICC line. There were two options not checked: one option was "Do not pull PICC line at end of therapy and maintain through:_____." The other option was "Send patient to Interventional Radiology for line removal at end of course." On the bottom of the form Under Antibiotics was written "Cefepime 1 gram IV (intravenously) every 8 hours through 11/25/2015." Review of the Admission orders for Readmission to the facility on 11/18/2015 revealed orders handwritten on a Physician's order sheet for 11/18/15-11/30/15. On Page 2 under the list of handwritten medications, the medication order in the second box read: Cefepime 1 gram in 100 milliliters of normal saline every 8 hours via PICC line, Stop date 11/25/15. On the right hand side of page 3, the area was checked for IV (Intravenous) ABT (Antibiotic Therapy) for diagnosis of Urosepsis with a stop date of 11/25/2015. The readmission orders were signed by the physician on 11/21/2015. On 1/6/2017 at 11:25 AM, an interview was conducted with the facility Administrator (Admin A) who stated the facility had an order to discontinue the PICC line by the attending physician but also because the resident was being followed by Infectious Disease doctors, the facility wanted to be sure the resident was cleared by Infectious Disease before removing the PICC line. The Administrator stated the PICC line was removed on 12/2/2015 after the resident was cleared. On 1/6/2017 at 1:30 PM, the Administrator	F 309		

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(Admin A) stated she was positive that there was an order to remove the PICC line because she was the nurse who removed the PICC line. The Administrator (Admin A) was the Director of Nursing of the facility at the time Resident # 28 was in the facility. At approximately 1:45 PM, Admin A presented a copy of the Nurses Note dated 12/2/2015 at 4:10 PM which stated "Residents PICC line discontinued by writer without difficulty." Admin A also presented a copy of the orders from Infectious Disease physicians which ordered to "Pull PIC Line at the end of IV antibiotic course" and "May send patient to Interventional Radiology for line evaluation or replacement as needed". Under Antibiotics was written "Cefepime 1 gram IV (intravenously) every 8 hours through 11/25/2015."

During the end of day debriefing on 1/6/2017, the facility Administrator, Acting Director of Nursing and Chief Executive Officer were informed of the findings.

Guidance given from Potter and Perry, Fundamentals of Nursing, Eighth Edition, page 305 read: "Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Therefore you need to assess all orders; if you find one to be erroneous or harmful, further clarification from the health care provider is necessary."
No further information was provided.

Review of the Hospital Discharge Note dated 11/18/2015 revealed orders to "remove the PICC line after antibiotic completed 11/25"

Review of the Infectious Disease Outpatient Antibiotic Orders showed orders for the PICC line

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for Indication: Urosepsis Proteus Bacteremia. The orders were for 2. weekly labs; 7. PICC line: "Pull PICC Line at the end of IV antibiotic course" and "May send patient to Interventional Radiology for line evaluation or replacement as needed". There were 4 options for orders from the physician regarding the PICC line. There were two options not checked: one option was "Do not pull PICC line at end of therapy and maintain through:_____. The other option was Send patient to Interventional Radiology for line removal at end of course.
Under Antibiotics was written "Cefepime 1 gram IV (intravenously) every 8 hours through 11/25/2015."

On 1/6/2017 at 11:25 AM, an interview was conducted with the facility Administrator (Admin A) who stated the facility had an order to discontinue the PICC line by the attending physician but also because the resident was being followed by Infectious Disease doctors, the facility wanted to be sure the resident was cleared by Infectious Disease before removing the PICC line. The Administrator stated the PICC line was removed on 12/2/2015 after the resident was cleared.

On 1/6/2017 at 1:30 PM, the Administrator (Admin A) stated she was positive that there was an order to remove the PICC line because she was the nurse who removed the PICC line. The Administrator (Admin A) was the Director of Nursing of the facility at the time Resident # 28 was in the facility. At approximately 1:45 PM, Admin A presented a copy of the Nurses Note dated 12/2/2015 at 4:10 PM which stated "Residents PICC line discontinued by writer without difficulty." Admin A also presented a copy

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F 309	Continued From page 45 of the orders from Infectious Disease physicians which ordered to "Pull PICC Line at the end of IV antibiotic course" and "May send patient to Interventional Radiology for line evaluation or replacement as needed". Under Antibiotics was written "Cefepime 1 gram IV (intravenously) every 8 hours through 11/25/2015."	F 309		
F 323 SS=D	COMPLAINT DEFICIENCY FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are	F 323		2/7/17

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F 323	Continued From page 46 appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure a safe environment for 1 resident (Resident #15) of 31 residents in the survey sample. For Resident #15 the facility staff failed to remove a caddy containing lancets and a sharps container from the bedside table and failed to ensure a chair alarm was applied to the wheel chair. The findings included: Resident #15, a 79 year old, was admitted to the facility on 12/31/13. Her diagnoses included Alzheimer's disease, dementia, dysphagia, hypertension, elevated lipids and osteoporosis. Her most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 12/1/16. She was coded with a severe cognitive impairment and required extensive assistance with activities of daily living. A) Lancets/ sharps container During the initial tour of the facility on 1/4/17 at 12:50 p.m., a red plastic caddy containing a glucometer, 36 unused lancets in a cup and a small sharps container containing used lancets and a syringe were observed on Resident #15's bedside table. No residents were in the room at this time. There were no residents or staff in the vicinity of the room. Shortly after the observation, the Administrator	F 323	F323 Corrective Action(s): The caddy was removed from the bedside of Resident # 15. The attending physician and responsible party for Resident #15 were notified of the incident. A 100% audit was completed of the facility to ensure a safe environment. The attending physician and responsible party for Resident # 15 were notified that she did not have a chair alarm in place. Identification of Deficient Practice & Corrective Action(s): All residents have been potentially been affected by an unsafe environment. A 100% audit was completed of the facility to ensure a safe environment. All residents who utilize a bed and/ or chair alarm as a fall intervention may have been potentially affected. The DON and/or designee will do a 100% review all residents who utilize a bed and/ or chair alarm as a fall intervention to ensure all orders are transcribed correctly and supplies are available. Any/all negative findings will be communicated to the DON for corrective action. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. The DON and/or	

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F 323	Continued From page 47 was walking through the unit and was asked to observe the caddy on the bedside table. The Administrator stated that the caddy should not be in the room. She removed it from the bedside table. B) Chair alarm Resident #15 had a history of falls, with her most recent fall on 12/31/16. According to the plan of care, a bed alarm was to be used when Resident #15 was in bed and a chair alarm was to be used when she was in the wheel chair. Resident #15 was observed on 1/5/17 at 8:40 a.m. She was seated in her wheel chair at a table in the dining room waiting for breakfast. There was no chair alarm attached to the wheel chair. On 1/5/17 at 9:20 a.m., Licensed Practical Nurse D (LPN D), Unit Manager, was asked to identify the bed alarm on Resident 15's bed. There was no alarm on the bed at this time. LPN D stated that it was probably attached to the wheel chair. LPN D was told that it did not appear that Resident #15 had an alarm attached to the wheel chair. LPN D stated she would look for the alarm placement after staff finished feeding Resident #15 her breakfast. After breakfast at 9:30 a.m., LPN D and another staff were observed attaching a chair alarm to Resident #15's wheel chair. When asked if they were just now applying the alarm, LPN D stated that the sensor pad had been in the wheel chair but the monitor device had not been attached. LPN D stated they were attaching the monitor device at that time.	F 323	designee will educate all staff on Safety hazards in resident care areas including safe handling of supply caddies. The DON and/or designee will educate the Nursing staff on the use of fall interventions. Monitoring: The DON is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The DON and/or designee will complete QA Audit- Safety hazards and QA Audit- Fall interventions weekly for twelve weeks to monitor for compliance. Any/all negative findings will be corrected immediately and reported to the DON for corrective action and appropriate disciplinary action. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	

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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 323	Continued From page 48 At the end of day meeting on 1/6/17, the Administrator and Director of Nursing were notified that Resident #15 had been observed without a chair alarm. It was also reviewed that a caddy containing lancets and a sharps container was observed on the bedside table.	F 323		
F 333 SS=D	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) 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 to ensure 1 resident (Resident #10) of 31 residents in the survey sample was free from a significant medication error. For Resident #10 the facility staff failed to administer Coumadin (blood thinner) on 1/3/17. The findings included: Resident #10, a 93 year old, was admitted to the facility on 3/1/16. Her diagnoses included dementia, anxiety, diabetes, rheumatoid arthritis and hypothyroidism. Resident #10's most recent Minimum Data Set assessment was a 5 day assessment with an assessment reference date of 12/5/16. She was	F 333	F333 Corrective Action(s): The attending physician and responsible parties for Residents # 10 have been notified of the omission of documentation for medication administration. A facility Incident and Accident report form was completed for these incidents. Identification of Deficient Practice & Corrective Action(s): All other residents receiving medications may have been potentially affected. The DON and/or designee will do a 100% review all resident medication and treatment records to ensure all orders are transcribed correctly and medications and treatment supplies are available. Any/all	2/7/17

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F 333	Continued From page 49 coded with a Brief Interview of Mental Status score of 8 indicating moderate cognitive impairment. She required extensive assistance with activities of daily living. Resident #10 was diagnosed with a deep vein thrombosis (blood clot) on 12/16/16. Coumadin therapy was initiated by the physician. A telephone order regarding Coumadin administration dated 1/3/17 was included in the clinical record. The order read "INR (international normalized ratio) (1/2/17) Lovenox BID (two times per day) 80/0.8 ml (milliliter) injection and Coumadin Tues + Wed 3.0 mg (milligram) 1/03, 1/04. Recheck INR Thurs 1/05." According to the January 2017 Medication Administration Record (MAR), Coumadin was not administered on 1/3/17. The issue was reviewed with the Administrator. The Administrator provided a copy of a "Medication Error Report" and stated that the missed Coumadin administration was written up as a medication error. The error report documented the date of the error on 1/3/17. The report read "Coumadin 3 mg (1) tab po (by mouth) q (every) evening- medication not administered." The INR was rechecked on 1/5/17. The physician was notified of the error and a new Coumadin order was obtained. The following information about Coumadin use was accessed on 1/10/17 at 10:51 a.m. at the website https://www.drugs.com/coumadin.html. "Coumadin (warfarin) is an anticoagulant (blood thinner). Warfarin reduces the formation of blood clots. Coumadin is used to treat or prevent blood	F 333	negative findings will be communicated to the DON for corrective action. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. Licensed Nursing staff will be educated by the DON and/or designee on the policy and procedure for the proper administration and delivery of medications and treatments. Monitoring: The DON is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The DON and/or designee will conduct random weekly medication pass and treatment observations audits to monitor compliance. Any/all negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	

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F 333	Continued From page 50 clots in veins or arteries, which can reduce the risk of stroke, heart attack, or other serious conditions." "Take Coumadin exactly as prescribed by your doctor. Follow all directions on your prescription label. Your doctor may occasionally change your dose to make sure you get the best results. Do not take Coumadin in larger or smaller amounts or for longer than your doctor tells you to. Take Coumadin at the same time every day. Never take a double dose of this medicine." The Coumadin medication error was reviewed with the Administrator and Director of Nursing at the end of day meeting on 1/6/17.	F 333		
F 354 SS=F	COMPLAINT DEFICIENCY WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON CFR(s): 483.35(b)(1)-(3) (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review the facility staff failed to ensure a full time DON (director of nursing) was	F 354	F 354 Corrective Action(s): Tyler Harrell, RN, BSN was designated as	2/7/17

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F 354	Continued From page 51 functioning at the facility. The interim DON was also functioning as a unit manager and the ADON (assistant director of nursing). The findings included: Upon entry to the facility 1/4/17 at approximately 12 noon, the current administrator, ADM A stated ADM C was functioning as the interim DON. ADM A stated she (ADM C) had been the DON and sometime during December 2016, ADM C had become the interim DON. ADM A stated the SA (state agency) had been informed and the facility was currently recruiting for the position. Review of the daily as worked staffing revealed ADM C was still functioning as the facility ADON and unit manager for the Clover Hill unit. ADM C was interviewed 1/5/17 at 10:28 a.m. ADM C stated she had been appointed interim DON during December, 2016. ADM C stated she was still functioning as the facility's ADON and also the Clover Hill unit manager. ADM C stated she had been the unit manager for a number of years. ADM C stated there was no other unit manager for Clover Hill unit. She stated there was a separate unit manager for all of the other units and the as work daily staffing confirmed that. ADM C stated she had "split some of the DON duties" with ADM A (the facility administrator). The night shift supervisor (RN J) was interviewed 1/5/17 at 11:10 p.m. RN J stated she had been employed by the facility for approximately three	F 354	the Director of Nursing on December 2, 2016. On January 23, 2017, Katrina Moody LPN was named interim Unit manager for the Clover Hill unit and staff/residents were given notification of this change. Identification of Deficient Practice & Corrective Action(s): All residents could have been potentially affected. Active recruitment for a Director of Nursing is proceeding. Updates for DON status will be communicated to the resident council and staff as changes occur. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. Effective immediately an Interim unit Manager/ADON has been designated to oversee the Clover Hill neighborhood. Staff have been provided a written notice of the change. Monitoring: The DON is responsible for maintaining compliance. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	

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F 354	Continued From page 52 years and worked 11-7 as a permanent shift. RN J stated she would contact the facility DON if there was any allegation of abuse, neglect, or mistreatment as part of implementing the abuse policy. RN J stated she would contact ADM A (the administrator) as her understanding was that ADM A was functioning as the DON and administrator. RN J stated ADM C was the unit manager for Clover Hill and functioned as the ADON for the facility. LPN D, a unit manager for the 500 rooms was interviewed, 1/6/17 at 10:52 a.m. LPN D stated ADM A "is the DON/administrator." ADM C was the "ADON." ADM A stated 1/6/17 at 11 a.m. the facility had notified the SA that ADM C was the interim DON. ADM A stated she thought ADM C misspoke when she (ADM C) stated she was the interim DON, ADON, and unit manager. ADM A stated part of the DON function was to coordinate and assess care for the entire facility. ADM A stated ADM C was performing that duty by also being the ADON and unit manager on her unit. The administrator (ADM A) and ADON (ADM C) were informed of the failure of the facility to ensure a full time DON was in place and functioning as a full time DON, 1/6/17 at 11 a.m.	F 354		
F 367 SS=D	THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN CFR(s): 483.60(e)(1)(2) (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician.	F 367		2/7/17

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F 367	Continued From page 53 (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure one Resident (Resident #16) in a survey sample of 31 Residents, received a physician ordered therapeutic diet. Resident #16 was not administered "peanut butter cups" as a weight gain supplement per physician's orders as they were "not available." The findings included: Resident #16, a female, was initially admitted to the facility 3/15/05. Her diagnoses included vascular dementia, vertebral compression fracture, Bell's palsy, dysthrymic disorder, Parkinson's disease, arthropathy, osteoporosis, dysphagia, and hypertension. Resident #16's most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/18/16 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #16 was coded as needing extensive assistance of one staff member to perform her activities of daily living with the exception of eating. For eating she was coded as needing setup assistance only. Resident #16 was coded as being 63 inches tall and weighed 128 pounds, having gained three	F 367	F367 Corrective Action(s): The attending physician and responsible parties for Residents # 16 have been notified of the omission of documentation for administration of Peanut Butter cups. A facility Incident and Accident report form was completed for these incidents. Identification of Deficient Practice & Corrective Action(s): All other residents receiving dietary supplements may have been potentially affected. The DON and/or designee will do a 100% review all resident medication and treatment records to ensure all orders for dietary supplements are transcribed correctly and dietary supplements are available. Any/all negative findings will be communicated to the DON for corrective action. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. Licensed Nursing staff will be educated by the DON and/or designee on the policy and procedure for the proper administration and delivery of physician ordered supplements.	

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F 367	Continued From page 54 pounds since May, 2016. Review of Resident #16's clinical record revealed she had experienced some weight loss and the interdisciplinary team, including the dietitian developed a plan to give her peanut butter cups twice daily as a nutritional supplement. A signed physician's order for "1 peanut butter cup twice daily for supplement" was obtained on 5/12/16. An accompanying entry was placed on the eMAR (electronic medication administration record). Nurses' initials were evident that the peanut butter cup was administered twice daily with the exception of 10/29/16 at 5 p.m., 12/24/16 at 5 p.m. and 1/2/16 at 8 a.m. A code was put in the eMAR indicating the peanut butter cup was not administered and referred the reader to the nursing notes for clarification. Documentation in the nursing notes indicated the peanut butter cups were not administered as they were "not available." When interviewed, the administrator stated the kitchen was responsible for ordering the peanut butter cups. The cups were then delivered to the units, labeled with the Resident's name. The administrator stated she did not know how the peanut butter cups were not available for administration to Resident #16, 1/5/16 at 4:55 p.m. Documentation was evident that Resident #16 had experienced a slow steady weight gain since the peanut butter cups were administered. The administrator and ADON were informed of the failure of the staff to ensure physician ordered peanut butter cups were available for	F 367	Monitoring: The DON is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The DON and/or designee will conduct random weekly medication pass and treatment and to verify the supplements are available audits to monitor compliance. Any/all negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	

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F 367	Continued From page 55 administration to Resident #16, 1/6/17 at 11 a.m.	F 367		
F 386 SS=D	PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS CFR(s): 483.30(b)(1)-(3) (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed for 2 residents (Residents# 23 and 26) of 31 residents in the survey sample to ensure the physician signed and dated orders at each visit. 1. For Resident #23, the facility staff failed to ensure physician orders were signed. 2. For Resident #26, the facility staff failed to ensure the physician signed all orders after 10/7/16. The findings included: 1. For Resident #23, the facility staff failed to ensure physician orders were signed.	F 386	F 386 Corrective Action(s): The Attending physicians for Resident #23 and 26 did not sign and date orders at each visit. Resident #23 and 26 have current orders signed. . Identification of Deficient Practice & Corrective Action(s): All residents may have been potentially affected. A 100% audit of all residents clinical records will be completed to identify residents at risk. All negative findings will be addressed at the time of discovery. To include notification to the attending Physicians of the residents who have orders not dated and signed.	2/7/17

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F 386	Continued From page 56 Resident #23, an 85 year old, was admitted to the facility on 7/1/16. Her diagnoses included anxiety, reflux, anemia, depression, hypertension, dementia, diabetes, chronic kidney disease and hypothyroidism. Resident #23's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 10/8/16. She was coded with a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment. She required assistance with activities of daily living. Resident #23's clinical record was reviewed. The most recent signed physician order sheet available on the clinical record was dated 8/24/16. Physician order sheets dated 10/1/16, 10/31/16 and 11/17/16 were available on the record but they were not signed. At the end of day meeting on 1/6/17, the Administrator and Director of Nursing were notified regarding the physician orders. No further information was provided. 2. For Resident #26, the facility staff failed to ensure the physician signed all orders after 10/7/16. Resident #26, a female, was admitted to the facility 8/1/16. Her diagnoses included respiratory failure with hypoxia, anemia of chronic kidney disease, hypothyroidism, type II diabetes mellitus, hyperlipidemia, hypertension, congestive heart failure, cerebral infarction, and right hemiplegia. Resident #26's most recent MDS (minimum data set) with an ARD (assessment reference date) of	F 386	Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All attending Physicians groups have been informed and issued a copy of the State and Federal guidelines for Physician visits and monitoring the resident medical plan of care. Any physician identified to be out of compliance will be notified by fax and phone. The DON and/or designee will educate licensed nursing staff on the State and Federal guidelines for Physician visits and the monitoring of the medical plan of care. Monitoring: The Administrator is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The QA Audit, Physician Visit audit will be completed by the Administrator and/or designee weekly to ensure timely physician visit compliance. Any/all negative findings will be reported to the administrator for corrective action. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	

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F 386	Continued From page 57 11/7/16 was coded as a quarterly assessment. She was coded as having no memory deficits and was able to make her own daily life decisions. Resident #26 was coded as requiring extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating, she was coded as needing stand by assistance. Review of Resident #26's clinical record revealed no signed "Physician's Order Summary Report " since 10/7/16. The "Order Summary Report" was a cumulative and current listing of the comprehensive plan of care for Resident #26 and the physician's signature was required by the facility as a review and agreement with the plan of care. Physician's notes were evident that the physician had been in and assessed Resident #26 on the following days after 10/7/16: 11/10/16, 12/16/16, 12/19/16, 12/21/16, 12/28/16, and 12/29/16. RN (registered nurse) A, the unit manager, stated 1/6/16 at 10:15 a.m., if the physician had signed the order summary, the form would be in the current clinical record. RN A reviewed Resident #26's clinical record and stated she also did not see that the order summary had been signed after 10/7/16. The administrator and ADON (assistant director of nursing) were informed of the failure of the staff to ensure Resident #26's physician's order summary was signed by the physician after 10/7/16 and that orders were signed at each visit, 1/6/17 at 11 a.m.	F 386		
F 387	FREQUENCY & TIMELINESS OF PHYSICIAN	F 387		2/7/17

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F 387 SS=D	Continued From page 58 VISIT CFR(s): 483.30(c)(1)(2) (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. 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 for one (Resident #22) of 31 residents in the survey same, physician visits were timely. Resident #22's last physician's visit was 6/8/16 which was over 6 months from the required physician visit time. The findings included: Resident #22 was admitted to the facility on 1/26/15 with the diagnoses of, but not limited to, dementia, diabetes mellitus type 2 and hypertension. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 10/11/16. The MDS coded Resident #22 with intact cognition; required limited assistance from staff for bed mobility, transfers, ambulation, toileting and hygiene; and extensive assistance from staff for dressing and bathing.	F 387	F 387 Corrective Action(s): The Attending physician for Resident #22 did not complete the monthly visit in a timely manner. Resident # 22 physician visits are current and in compliance with requirements. Identification of Deficient Practice & Corrective Action(s): All residents may have been potentially affected. A 100% audit of all residents clinical records will be completed to identify residents at risk. All negative findings will be addressed at the time of discovery. To include notification to the attending Physicians of the tardiness with the residents visit for completion Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All attending Physicians have been in- serviced and issued a copy of the State and Federal	

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F 387	Continued From page 59 On 1/6/17 at 8:45 a.m. Resident #22's clinical record was reviewed. The review revealed the last physician's progress note was dated 3/26/15. There were no progress notes in the clinical record dated after 3/26/15. An interview was conducted with the Unit Manager, Licensed Practical Nurse-F (LPN-F) at the time of the review. LPN-F stated "The doctor normally doesn't come here. The daughter takes her to the doctor's office." She explained that the facility staff call the doctor's office when needed or the daughter communicates with the office and facility. When asked how she knows if the regulatory requirements are being met, LPN-F stated "I'll have to call the office to see when she was seen." She stated "We can get a fax of the visit." On 1/6/17 at 9:40 a.m. an interview was conducted with the Administrator (Admin-A). Surveyor informed Admin-A of the last documented physician's visit of 3/26/15. Admin-A stated "Doctor (name) is her attending (doctor), the family takes them on a whim." Admin-A stated "We don't have the documentation that's required but we are checking with the office." On 1/6/17 at 10:15 a.m., Admin-A presented faxed copies of physician progress notes dated 6/8/16, 6/22/15 and prior visits. There was no documentation provided that Resident #22 was seen by her physician after 6/8/16. On 1/6/17 at 11:35 a.m. the acting Director of Nursing and CEO with Admin-A in attendance, were informed of the late physician's visits. A facility policy and expectation of timely physician visits were requested.	F 387	guidelines for Physician visits and monitoring the resident medical plan of care. Any physician identified to be out of compliance will be notified by fax and phone of the untimely physician visit. If compliance is not established within, 24-hours the Medical Director will be notified of the noncompliance by the attending physician and she and/or designee will perform the required visit. The DON and/or designee will educate licensed nursing staff on the State and Federal guidelines for Physician visits and the monitoring of the medical plan of care. Monitoring: The Administrator is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The QA Audit, Physician Visit audit will be completed by the Administrator and/or designee weekly for twelve weeks to ensure timely physician visit compliance. Any/all negative findings will be reported to the administrator for corrective action. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495079	A. BUILDING _____ B. WING _____	C 01/06/2017

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F 387	Continued From page 60 On 1/6/17 at 2:25 p.m., when asked how often physician visits should occur, Admin-A stated the physician "Should see Resident every 60 days and review their meds and careplan." No further information was provided by the facility staff.	F 387		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 441		2/7/17

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F 441	Continued From page 61 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the infection control	F 441	F441 Corrective Action(s):	

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F 441	Continued From page 62 committee failed to ensure an effective infection control program was implemented. During the medication administration observation, Licensed Practical Nurse-B (LPN-B) failed to ensure a glucometer (hand held device to test blood sugar levels) and carry caddy were sanitized after use. Also, the carry caddy did not have a barrier underneath it when placed on the overbed table and then brought back to the medication counter top. The findings included: On 1/4/17 at 4:40 p.m. a medication pass observation was conducted with LPN-B. LPN-B brought a blue plastic carry caddy which contained a glucometer and testing supplies (alcohol pads, lancets, testing strips and gauze) into Resident #26's room. LPN-B placed a paper towel on the overbed table which was positioned next to Resident #26's bed then placed the glucometer on the paper towel. LPN-B placed the plastic caddy directly on the overbed table without having a barrier underneath. LPN-B donned gloves and obtained Resident #26's blood with the testing strip and glucometer properly. She disposed of the gloves properly. LPN-B exited the resident's room, placed the glucometer and carry basket on top of the medication cart without cleaning them. LPN-B donned disposable gloves, removed a Clorox disinfecting wipe and wiped the opening of the glucometer (where the testing strip is inserted) rather than the whole machine. She then placed the glucometer back in the carry caddy, removed the caddy from the top of the medication cart and	F 441	The nurse that failed to ensure an effective infection control was educated on sanitation of the glucometer and carrier/caddie. Identification of Deficient Practice & Corrective Action(s): All residents requiring blood glucose monitoring may have been potentially affected. The DON and/or designee will complete a clinical record review of current resident to identify residents who require blood glucose monitoring. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. The DON and/or designee will educate the Healthcare center staff on Infection Control policy and procedures, including maintaining an effective infection control program. The DON and/or designee will educate licensed nurses on the Blood Glucose monitoring policy, including the cleaning procedures of the glucometer and equipment caddie. Monitoring: The DON is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The QA Audit, Infection control- Blood glucose, will be completed weekly by the DON and/or designee to monitor for compliance. Any/all negative findings will be reported to the DON for corrective action. Aggregate findings of these audits will be provided to the Quality Assurance	

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F 441	Continued From page 63 brought it into the medication room. LPN-B placed the caddy on the medication room countertop. LPN-B did not have another blood glucose test to perform or other medications to administer after the time of observation. Resident #26, a female, was admitted to the facility 8/1/16. Her diagnoses included, but not limited to, type II diabetes mellitus, congestive heart failure, cerebral infarction, and right hemiplegia. Resident #26's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/7/16 was coded as a quarterly assessment. She was coded as having no memory deficits and was able to make her own daily life decisions. Resident #26 was coded as requiring extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating, she was coded as needing stand by assistance. On 1/4/17 at 4:55 p.m., with Unit Manager, Registered Nurse-A (RN-A) present, an interview with LPN-B was conducted. When the surveyor discussed the observed infection control concern with LPN-B, she replied "Oh, I should just bring in the glucometer and supplies then." LPN-B stated "I did use a paper towel under supplies." It was discussed that the carry caddy did not have a barrier underneath and it went from the resident's room to the cart and into the medication room. On 1/5/17 at 4:35 p.m. the acting Director of Nursing, Administrator and CEO were informed of the infection control concern during the medication administration observation. No information was provided by the facility staff at the	F 441	Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 7, 2017	

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F 441	Continued From page 64 time the administration was informed. On 1/6/17 at 9:05 a.m. the "Infection Control Program" policy was reviewed with the Infection Control Preventionist, the acting Director of Nursing (Admin-C). The policy included: "...To provide a safe, sanitary, comfortable environment and to investigate, control and help prevent infections in the facility." On 1/6/17 at 11:30 a.m., Admin-A (the Administrator) and Admin-C were asked what the expectation of bringing the carry case (caddy) into the rooms and the blood glucose policy was requested. No information was given by administration at the time. Admin-A provided the blood glucose policy and stated on 1/6/17 at 2:10 p.m. "There is no expectation to bring a caddy into the room." The facility policy titled "BLOOD GLUCOSE TEST PROCEDURE (FINGERSTICK)" was reviewed and included: "...Procedure:...9. Clean the machine with the facility approved disinfecting wipe." No further information was provided by the facility staff.	F 441		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 514		2/7/17

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F 514	Continued From page 65 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to ensure, for one (Resident #22) of 31 residents in the survey sample, a complete clinical record. For Resident #22, the facility staff failed to ensure physician progress notes were available for review in the clinical record.	F 514	F514 Corrective Action(s): The medical record for Resident #22 was corrected at the time of discovery to accurately reflect all physician progress notes. Identification of Deficient Practice & Corrective Action(s):	

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F 514	Continued From page 66 The findings included: Resident #22 was admitted to the facility on 1/26/15 with the diagnoses of, but not limited to, dementia, diabetes mellitus type 2 and hypertension. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 10/11/16. The MDS coded Resident #22 with intact cognition; required limited assistance from staff for bed mobility, transfers, ambulation, toileting and hygiene; and extensive assistance from staff for dressing and bathing. On 1/6/17 at 8:45 a.m. Resident #22's clinical record was reviewed. The review revealed the last physician's progress note was dated 3/26/15. There were no progress notes in the clinical record dated after 3/26/15. An interview was conducted with the Unit Manager, Licensed Practical Nurse-F (LPN-F) at the time of the review. LPN-F stated, "The doctor normally doesn't come here. The daughter takes her to the doctor's office." She explained that the facility staff call the doctor's office when needed or the daughter communicates with the office and facility. When asked how she knows if the regulatory requirements are being met, LPN-F stated, "I'll have to call the office to see when she was seen." She stated, "We can get a fax of the visit." On 1/6/17 at 9:40 a.m. an interview was conducted with the Administrator (Admin-A). Surveyor informed Admin-A of the last documented physician's visit of 3/26/15. Admin-A stated "Doctor (name) is her attending (doctor),	F 514	All residents may have been potentially affected. A 100% audit resident medical records have been conducted by the DON and /or designee to identify residents at risk. Any/all negative findings will be corrected on discovery and reported to the DON for corrective action. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. The DON and/or designee will be educate the Unit secretaries, neighborhood care managers and Licensed nurses on maintaining a complete medical record including physician progress notes and clinical documentation standards per the facility□s policy and procedure. The training will include the procedure for receiving and reviewing all physician progress notes after an office visit. Monitoring: The DON is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The QA Audit tool, Physician progress notes audit will be completed weekly for monitor for compliance. Any/all negative findings will be reported to the DON and attending physician for corrective action. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 3, 2017	

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F 514	Continued From page 67 the family takes them on a whim." Admin-A stated "We don't have the documentation that's required but we are checking with the office." On 1/6/17 at 10:15 a.m., Admin-A presented faxed copies of physician progress notes dated 6/8/16, 6/22/15 and prior visits. There was no documentation provided that Resident #22 was seen by her physician after 6/8/16. On 1/6/17 at 11:35 a.m., the acting Director of Nursing, CEO (Chief Executive Officer) and Administrator were informed of the progress notes not being in the clinical record. No further information was provided by the facility staff.	F 514		