STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495366	A. BUILDING _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PRINCE WOODS, INC	100 ANNA GOODE WAY SUFFOLK, VA 23434

(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 11/14/17 through 11/16/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 40 certified bed facility was 25 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents 1 through 8, Resident 10 and Resident 14. Closed record reviews included (Residents 9,11, 12 and Resident 13).	F 000		
F 157 SS=E	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 157		11/17/17

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

Electronically Signed | 12/11/2017

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F 157	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical recorded review and facility documentation, the facility staff failed to follow physician orders for 1 out 16 (Resident #1) in the survey sample. The facility staff failed to notify the physician that the following medications were not administered as ordered: *Phoslo 667 capsule for Resident #1. The findings included:	F 157	Prefix Tag: F157 Notify Of Changes (Injury/Decline/Room, etc) CFR(s):483.10(g)(14) It is the intent of this facility to assure physician□s are notified timely when medications not administered as ordered. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice.	

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F 157	Continued From page 2 Resident #1 was admitted to the facility on 08/18/17. Diagnosis for Resident #1 included but are not limited to *End Stage Renal Disease (ESRD) and Right *Femur Fracture. The current Minimum Data Set (MDS) a 30-day assessment with an Assessment Reference Date (ARD) of 09/15/17 coded the resident with a 08 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #1 requiring total dependence of one with bathing, extensive assistance of two with transfers and mobility, extensive assistance of one with dressing, hygiene and toilet use, and limited assistance of one with eating. Resident #1 was coded frequently incontinent of bowel and bladder. *Phoslo is used to prevent high blood phosphate levels in patients who are on dialysis due to severe kidney disease (www.webmd.com). *End Stage Renal Disease is the last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs(https://medlineplus.gov/ency/article/000500.htm). *Hip Fracture is a hip fracture is a break in the upper part of the thigh bone(femur) where the thighbone joins the pelvis to form the hip joint (www.webmd.com/osteoporosis/hip-fracture). Review of Resident #1's Physician orders and Medication Administration Record (MAR) for September, October and November 2017 indicated the following medication orders:	F 157	Resident # 1: Dr. Jackson was contacted. Order clarification was given 11/17/17. New order entered PhosLo 667mg 1 capsule tid, change frequency to 2 times daily on dialysis days. On 11/17/17, a Medication Error Report was completed. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: DON and RN Charge Nurse immediately reviewed the medication administration records for all residents currently residing in the community. No other residents were identified having missed any medication dosages due to leaving the community routinely for treatments/procedures. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. The DON and Nurse Manager will review the Medication Administration Records to capture Exception Report in the Electronic Health Record [EHR] , to assure all medications were administered according to physician orders. All notations indicating (Resident Not available/Out of Facility) will be reviewed with the nurse responsible for follow-up and additional training. Any resident who routinely leaves the facility for treatments will have their	

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F 157	Continued From page 3 1). Phoslo 667 mg capsule - oral three times daily scheduled to be administered at 8 a.m., 11:30 a.m., and 5:00 p.m. for ESRD. During the review of Resident #1's Medication Administration Audit Record for September, October and November 2017 revealed the following medication were not administered due to resident out of facility at dialysis: 1). Phoslo 667 was document as not being administered at 11:30 a.m., in September 2017 on the following days: 9/4, 9/8, 9/11, 9/13/ 9/15, 9/18, 9/20, 9/22, 9/25, 9/27 and 9/29/2017. 2). Phoslo 667 was document as not being administered at 11:30 a.m., in October 2017 on the following days: 10/2, 10/4, 10/6, 10/9, 10/11, 10/16, 10/20, 10/23, 10/25 and 10/27/17. 3). Phoslo 667 was document as not being administered at 11:30 a.m., in November 2017 on the following days: 11/1, 11/3, 11/6 and 11/13/17. The review of Resident #1's clinical record did not indicate that the physican was notified that the resident missed multiple doses of Phoslo due to resident being out to dialysis. On 11/16/17 at appropriately 1:40 p.m., and interview was conducted with the NP who stated, Resident #1 was under another provider until October 20, 2017 but the nurses should have contacted the physician to have his medication times adjusted; the times should have been adjusted." The surveyor asked, why is Phoslo given to dialysis patients, the NP stated, "Phoslo is a supplement that helps to prevent high	F 157	medication and treatment records reviewed for completeness of all orders upon return to the community by the shift nurse. When a medication or treatment has been missed the physician will be notified immediately. The physician will provide additional instructions as needed, including modifying orders when leaving facility routinely interferes with administration times. DON and Nurse Manager will review the MARS weekly to assure all medication has been given as ordered. 4) Facility□s plan to monitor its performance so solutions are sustained and integrated into the facility□s quality assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner. Prefix Tag: F278 Assessment Accuracy/Coordination/Certified CFR(S): 483.20(g)-(j) It is the intent of this facility to comply with the requirements to complete all sections	

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F 157	Continued From page 4 phosphate levels with dialysis patients, their kidneys don't work so the Phoslo helps to maintain that low phosphate level. The NP proceeded to say, "I do have concerns that Resident #1's medication wasn't administered because he was out to dialysis, the medication should to be administered appropriately; they should have contacted someone to have his medications adjusted to fit his dialysis days." The facility administration was informed of the finding during a briefing on 11/17/17 at approximately 2:30 p.m. The facility did not present any further information about the findings.	F 157	of the MDS, submit the MDS, and make corrections when errors are identified in accordance with the MDS 3.0 RAI User□s Manual. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. On 11/17/17, the MDS Coordinator reviewed Resident #6, Section V dated 5/8/17. MDS Coordinator failed to add the required documentation to the MDS prior to submission. Missed documentation was located and scanned into the EHR for supportive documentation. Staff member was immediately counselled on the required documentation (date and location of pertinent information) that was used in the decision making process for the 7 triggered areas identified. On 11/17/17, each care plan team members was provided training that detailed the required use of dates and location when in the decision making process of the triggered CAAs of the MDS. Team members received verbal instruction on 11/17/17 and then received written instruction. The section of V for resident #6 has been completed. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice:	

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F 157	Continued From page 5	F 157	On 11/17/17, The RN Charge nurse reviewed 100% of all residents who had a comprehensive MDSs completed in the last 4 months for completion of dates/location of all triggered CAAs. No other residents were affected. On 11/17/17, The RN Charge nurse requested current Missing OBRA Assessment Report from CMS. No other residents were identified. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur The RN Charge nurse will review each comprehensive MDS completed for accuracy of Section V. Nurse will audit all comprehensive assessments prior to submission. Any incomplete MDS Section V will be returned to the appropriate care plan team member for correction. The RN Charge nurse will review all comprehensive MDS assessments, Section V for accuracy and completeness at the time of submission for 1 month then every 2 months for 9 months. The RN Charge nurse will routinely review the Missing OBRA Assessment Report and will respond to issues as needed. The facility Administrator or DON will review the report after each submission for 1 month then every 2 months for 9 months. Review of missing assessment report has been added to the QAPI audit tool.	

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F 157	Continued From page 6	F 157	4) Facility□s plan to monitor its performance so solutions are sustained and integrated into the facility□s quality assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 9months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		11/17/17

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F 278	Continued From page 7 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, the facility staff failed to: 1. The facility staff failed to ensure that documentation dates were included in section "V" of the MDS for 1 Resident (Resident #6) of 14 Residents in the survey sample. The findings included: 1. Resident #6 was admitted to the facility on 6/20/15. Diagnoses for Resident #6 included but are not limited to Non-Alzheimer's Dementia* (1). Resident #6's Annual Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 5/8/17 coded Resident #6 with a BIMS (Brief Interview for Mental Status) score of 12 of 15, indicating a moderate cognitive impairment. Section "V" of the Annual MDS	F 278	Prefix Tag: F278 Assessment Accuracy/Coordination/Certified CFR(S): 483.20(g)-(j) It is the intent of this facility to comply with the requirements to complete all sections of the MDS. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. On 11/17/17, the MDS Coordinator reviewed Resident #6, Section V dated 5/8/17. MDS Coordinator failed to add the required documentation to the MDS prior to submission. Missed documentation was located and scanned into the EHR for supportive documentation. Staff member was immediately counselled on the required documentation (date and location of pertinent information) that was used in the	

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F 278	Continued From page 8 coded Resident #6 with the following CAA (Care Area Assessment) trigger areas: Cognition Urinary Incontinence ADL (Activity of Daily Living) functioning Continence Falls Dental Care Pressure Ulcer Section "V" of the Annual MDS (Minimum Data Set) did not include a notation of date and location for documentation related to the decision making process for the triggered areas listed above. The Facility provided a copy of pages (4-6 to 4-7) taken from the CMS's RAI (Resident Assessment Instrument) Version 3.0 Manual Chapter 4 that documented the following guidance: CAA documentation. CAA documentation helps to explain the basis for the care plan by showing how the IDT (Interdisciplinary Team) determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident: for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rational(s) for selecting specific interventions. Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan. Relevant documentation for each triggered CAA	F 278	decision making process for the 7 triggered areas identified. On 11/17/17, each care plan team members was provided training that detailed the required use of dates and location when in the decision making process of the triggered CAAs of the MDS. Team members received verbal instruction on 11/17/17 and then received written instruction. The section of V for resident #6 has been completed. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: On 11/17/17, The RN Charge nurse reviewed 100% of all residents who had a comprehensive MDSs completed in the last 4 months for completion of dates/location of all triggered CAAs. No other residents were affected. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur The RN Charge nurse will review each comprehensive MDS completed for accuracy of Section V. Nurse will audit all comprehensive assessments prior to submission. Any incomplete MDS Section V will be returned to the appropriate care plan team member for correction. The RN Charge nurse will	

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F 278	Continued From page 9 describes: causes and contributing factors; The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what exactly is the issue/problem for this resident and why it is a problem; Complications affecting or caused by the care area for this resident; Risk factors related to the presence of the condition that affects the staff's decision to proceed to care planning; Factors that must be considered in developing individualized care plan interventions, including the decision to care plan or not to care plan various findings for the individual resident; The need for additional evaluation by the attending physician and other health professionals, as appropriate; The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA; Use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's record. Also indicate in the column "Care Planning Decision" whether the triggered care area is addressed in the care plan. The Acting MDS Coordinator on 11/15/17 at approximately 2:30 p.m., stated: "Yes, there should be a date." when asked if there should be a corresponding note and date for Section V of the Annual MDS with ARD of 5/8/17 The facility administration was informed of the findings during a briefing on 11/14/17 at	F 278	review all comprehensive MDS assessments, Section V for accuracy and completeness at the time of submission for 1 month then every 2 months for 9 months. 4) Facility plan to monitor its performance so solutions are sustained and integrated into the facility□s quality assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 9months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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F 278	Continued From page 10 approximately 2:26 p.m. The facility did not present any further information about the findings.	F 278		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 279		11/20/17

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F 279	Continued From page 11 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, the facility staff failed to develop a psychoactive care plan for 1 of 16 residents (Resident #1) in the survey sample. The facility staff failed to develop a care plan for a Resident #1 who was receiving a psychoactive medication *Zoloft. The findings include: Resident #1 was admitted to the nursing facility on 08/18/2017. Diagnosis for included but not	F 279	Prefix Tag: 279 Develop Comprehensive Care plans CFR(s): 483.20 (d); 483.21(b)(1) It is the intent of this facility to assure psychoactive medications included in the care plan for each Resident receiving psychoactive medications. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. On 11/15/15, the licensed nurse updated	

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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 279	Continued From page 12 limited to *Adjustment disorder with depressed mood. *Zoloft is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life) (https://medlineplus.gov/ency/article/007365.htm). *Adjustment disorder with depressed mood is a group of symptoms, such as stress, feeling sad or hopeless, and physical symptoms that can occur after you go through a stressful life event (https://medlineplus.gov/ency/article/007365.htm). The current Minimum Data Set (MDS) a 30-day assessment with an Assessment Reference Date (ARD) of 09/15/17 coded the resident with a 08 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. The residents MDS was coded for the usage of antianxiety and antidepressant medication. The section N on the MDS under medications read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, the MDS was coded for receiving an antidepressant for 7 days. The review of Resident #1's comprehensive care did not include a care plan for psychoactive medication.	F 279	the care plan for Resident #1 to care plan the Resident's use of psychoactive medications. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: On 11/20/17, the DON and MDS Coordinator reviewed the pharmacy generated psychoactive medication list and reviewed each residents care plan that was identified with an order for the psychoactive medication. All care plans reflected the current use of psychoactive medications. On November 17, 2017 the DON, provided counseling and retraining to the nurse who missed care planning psychoactive medications for Resident #1. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. The MDS Nurse will review all new physician orders with attention to any psychoactive medication orders. The nurse will update each resident's care plan to reflect the new order daily times 16 weeks, The DON or RN Charge Nurse will review the 24 hour order report during the morning meeting and will receive a copy of the revised care plan daily x 4. The DON or RN Charge Nurse will review weekly with MDS Coordinator a list of all psychoactive medication orders to assure they have been added to the care plan.	

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F 279	Continued From page 13 An interview was conducted with the MDS Coordinator on 11/15/17 at approximately 2:15 p.m., who stated "Psychoactive medications are to be care planned but under the drug class and not the medication. The surveyor asked, is Zoloft a psychoactive medication and she it be care planned, the MDS Coordinator replied, "Yes - it's a psychoactive medication and it should have been care planned." On the same day at approximately 4:10 p.m., the MDS Coordinator reviewed Resident #1's entire care planned then stated, "It's not here, it wasn't care planned." On 11/16/17 at approximately 11:20 a.m., and interview was conducted with the Director of Nursing (DON) who stated, psychoactive medications should be care planned but under the drug class and not the medication. The facility administration was informed of the finding during a briefing on 11/17/17 at approximately 2:30 p.m. The facility did not present any further information about the findings. The facility's policy: Comprehensive Person-Centered Care Planning Guidelines (Revised 5/31/17). -Incorporate identified problem areas.	F 279	4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 309 SS=E	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	F 309		11/21/17

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F 309	Continued From page 14 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 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, resident interview, staff interview, facility documentation review, clinical record review the facility staff failed to: 1. The facility staff failed to ensure non-pharmacological interventions were attempted prior to the administration of analgesics for 1 Resident (Resident #4) of 14	F 309	Prefix Tag: 309 Provide Care/Services for Highest Well Being CFR(s): 483.24, 483.25(k)(l) It is the intent of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident□s	

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F 309	Continued From page 15 residents in the survey sample. 2. The facility staff failed to ensure non-pharmacological interventions were attempted prior to the administration of analgesics for 1 Resident (Resident #8) of 14 residents in the survey sample. 3. The facility staff failed to follow physician orders for the following medications: *Phoslo 667 capsule for Resident #1. 4. The facility staff failed to ensure non-pharmacological interventions were attempted prior the administration of prn (as needed) pain medication *Tylenol for Resident #1 of 14 residents in the survey sample. The findings included: 1. Resident #4 was admitted to the facility on 1/3/17. Diagnoses for Resident #4 included but are not limited to Rhabdomyolysis* (1). Resident #4's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 9/25/17 coded Resident #4 with a BIMS (Brief Interview for Mental Status) of 13 of 15 indicating no cognitive impairment. In addition, the Quarterly MDS coded Resident #4 as requiring extensive assistance with one staff person assistance for hygiene and bathing. Resident #4 was coded as requiring supervision with one staff person assistance for transfers, eating and toileting. Resident #4's Active/Current 1/10/17 to Present Care Plan documented the following problem:	F 309	comprehensive assessment and plan of care; and to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident□s choices. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. The prn analgesic orders were reviewed for resident #1, 4 and 8 on 11/16/17. Resident #1 physician was notified of the missed doses of Phoslo on 11/17/17; no labs or other assessments were ordered by the physician. All licensed nurses received verbal and written instruction on offering non-pharmacological interventions prior to the administration of analgesics. Nurses were instructed to document the interventions in the resident record. This training was completed on 11/21/17. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: On 11/21/17 the DON and RN Charge Nurse provided the nurses with written guidelines for documenting the offering of non-pharmacological interventions prior to the administration of analgesics for all patients with orders for analgesics. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not	

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F 309	Continued From page 16 Problem: Requires pain management monitoring secondary to prior TKR (Total Knee Replacement), arthropathy/arthritis joint pain and back pain. Interventions included but were not limited to: Implement the following nonpharmacological* (2) pain management program, specifically: distraction, massage, imagery, relaxation, aromatherapy, and application of heat or cold. Resident #4's Physician orders documented the following: 1/4/17 Acetaminophen 500 mg (milligrams) (1 tab) Tablet Oral as needed three times a day Resident #4's Clinical Record MAR (Medication Administration Record) for November 2017 documented the following administration times for Acetaminophen 500 mg (1) Tablet Oral as needed three times a day: Medline Plus documented: Acetaminophen is used to relieve mild to moderate pain 11/5/17 administered 9:58 a.m. 11/5/17 administered 16:27 (4:27 p.m.) 11/5/17 administered 21:19 (9:19 p.m.) 11/8/17 administered 10:00 a.m. 11/9/17 administered 17:25 (5:25 p.m.) 11/12/17 administered 8:27 a.m. All of the above administered doses were documented as being effective for Resident #4. On 11/16/17 at approximately 10:00 a.m., the Facility was requested to provide any	F 309	occur. All nurses were provided written guidelines on the documentation of offering non-pharmacological interventions for prn analgesic orders. RN Charge Nurse will review Nurse□s notes daily. Floor nurses are completing a monitoring tool prior to the administration of analgesics. This monitoring tool is reviewed daily. by the nurse manager or DON. Medication administration records for residents receiving prn analgesics will have the MAR reviewed weekly by the DON or Nurse Manager to assure non-pharmacological interventions are offered/provided prior to administration. 4) Facility□s plan to monitor its performance so solutions are sustained and integrated into the facility□s quality assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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documentation showing use of non-pharmacological interventions were completed prior to the use of the analgesic Acetaminophen. The facility did not provide any documentation.

The Director of Nursing (DON) on 11/16/17 at approximately 3:00 p.m. stated there was no documentation for non pharmacological measures prior to the administration of analgesics.

The Facility did not present a Policy for use of non pharmacological measures prior to the administration of pain medications.

The facility administration was informed of the findings during a briefing on 11/14/17 at approximately 2:26 p.m. The facility did not present any further information about the findings.

2. Resident #8 was admitted to the facility on 8/22/17. Diagnoses for Resident #8 included but are not limited to Fracture of Femur (leg bone) .

Resident #8's Admission Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 8/29/17 coded Resident #8 a BIMS (Brief Interview for Mental Status) of 01 of 15 indicating a severe cognitive impairment. In addition, the Admission MDS coded Resident #8 as requiring extensive assistance with one staff person assistance for transfers, bed mobility, dressing, toilet use, hygiene and bathing.

Resident #8's current/active Care Plan did not include a problem for pain.

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Resident #8's Physician orders documented the following:

8/22/17 Oxycodone -acetaminophen 5 mg - 325 mg tablet; 1 tab as needed every four hours

Medline Plus documented: Oxycodone is used to relieve moderate to severe pain

Resident #8's October 2017 MAR (Medication Administration Record) documented the following Oxycodone -acetaminophen 5 mg - 325 mg tablet administration times:

10/5/17 administered 16:35 (4:35 p.m.)
10/25/17 administered 18:04 (6:04 p.m.)

All of the above administered doses were documented as being effective for Resident #4.

On 11/16/17 at approximately 10:00 a.m., the Facility was requested to provide any documentation showing use of non-pharmacological interventions were completed prior to the use of the analgesic Acetaminophen. The facility did not provide any documentation.

The Director of Nursing (DON) on 11/16/17 at approximately 3:00 p.m. stated there was no documentation for non pharmacological measures prior to the administration of analgesics.

The Facility did not present a Policy for use of non pharmacological measures prior to the administration of pain medications.

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The facility administration was informed of the findings during a briefing on 11/14/17 at approximately 2:26 p.m. The facility did not present any further information about the findings.

Definitions:

1. Rhabdomyolysis: (rab-doe-my-OL-ih-sis) Mayoclinic.org documented: a rare condition that causes muscle cells to break down. The most common signs and symptoms of rhabdomyolysis include:
Severe muscle aching throughout the entire body...

2. Non-Pharmacological: Non medicine measures such as relaxation, aromatherapy, massage: the National Institute of Health documented: The guidelines recommend that practitioners consider these non-pharmacologic interventions as appropriate options when treating patients whose low-back pain does not improve with more conservative self-care.

3. Non-Alzheimer's Dementia: Medline Plus documented: Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there. A type of dementia not associated with Alzheimer's Disease.

The findings included:

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3. Resident #1 was admitted to the facility on 08/18/17. Diagnosis for Resident #1 included but are not limited to *End Stage Renal Disease (ESRD) and Right *femur fracture.

The current Minimum Data Set (MDS) a 30-day assessment with an Assessment Reference Date (ARD) of 09/15/17 coded the resident with a 08 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #1 requiring total dependence of one with bathing, extensive assistance of two with transfers and mobility, extensive assistance of one with dressing, hygiene and toilet use, and limited assistance of one with eating. Resident #1 was coded frequently incontinent of bowel and bladder.

*Phoslo is used to prevent high blood phosphate levels in patients who are on dialysis due to severe kidney disease (www. com).

*ESRD is the last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs (https://medlineplus.gov/ency/article/000500.htm).

*Hip Fracture is a hip fracture is a break in the upper part of the thigh bone (femur) where the thigh bone joins the pelvis to form the hip joint (www.webmd.com/osteoporosis/hip-fracture).

Review of Resident #1's Physician orders and Medication Administration Record (MAR) for September, October and November 2017 indicated the following medication orders:

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1). Phoslo 667 mg capsule -oral three times daily scheduled to be administered at 8 a.m., 11:30 a.m., and 5:00 p.m. for ESRD.

During the review of Resident #1's Medication Administration Audit Record for September, October and November 2017 revealed the following medication were not administered due to resident out of facility at dialysis:

1). Phoslo 667 was document as not being administered at 11:30 a.m., in September 2017 on the following days: 9/4, 9/6, 9/8, 9/11, 9/13/ 9/15, 9/18, 9/20, 9/22, 9/25, 9/27/2017.

2). Phoslo 667 was document as not being administered at 11:30 a.m., in October 2017 on the following days: 10/2, 10/4, 10/6, 10/9, 10/11, 10/16, 10/20, 10/23, 10/25, 10/27 and 10/30/17.

3). Phoslo 667 was document as not being administered at 11:30 a.m., in November 2017 on the following days: 11/1, 11/3, 11/6, 11/8 and 11/13/17.

The facility administration was informed of the finding during a briefing on 11/17/17 at approximately 2:30 p.m. The facility did not present any further information about the findings.

4. Resident #1 was admitted to the facility on 08/18/17. Diagnosis for Resident #1 included but are not limited to Right *Femur Fracture.

The current Minimum Data Set (MDS) a 30-day assessment with an Assessment Reference Date (ARD) of 09/15/17 coded the resident with a 08 of a total possible score of 15 on the Brief Interview

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for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #1 requiring total dependence of one with bathing, extensive assistance of two with transfers and mobility, extensive assistance of one with dressing, hygiene and toilet use, and limited assistance of one with eating. Resident #1 was coded frequently incontinent of bowel and bladder.

**Hip Fracture is a hip fracture is a break in the upper part of the thigh bone (femur) where the thigh bone joins the pelvis to form the hip joint (www.webmd.com/osteoporosis/hip-fracture).

Resident #1 received an order for *Tylenol Extra Strength 500 mg tablet (2 tabs) by oral as needed three times daily starting on 08/19/2017.

*Tylenol is used to relieve mild to moderate pain and to reduce fever (https://medlineplus/gov/drugingfo/meds/a682514 .html).

Review of the Medication Administration Record (MAR) indicated that Resident # 1 received Tylenol Extra Strength 500 mg tablet (2 tabs) on the following days without any non-pharmacological intervention prior to the administration of as needed pain medication:

In September 2017: 5th, 8th, 9th, 11th, 12th, 13th, 14th, 16th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd, 26th, 27th, 28th and 30th.

In October 2017: 5th, 13th, 25th, 29th and 30th.

In November 2017: 4th,5th, 7th, 11th, 12th,13th and 14th.

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F 309	Continued From page 23 An interview was conducted with Director of Nursing (DON) on 11/16/17 at 1:15 p.m., who stated she expect for the nurses to assess residents for their pain level but to try non-pharmacological interventions prior to the administration of prn pain medications; if non-pharmacological interventions are not effective then give prn pain mediation but to document the pain level and the effectiveness of the pain medication after being administered. The DON reviewed Resident #1's clinical record for documentation that non-pharmacological interventions were tried prior to the administration of prn Tylenol then replied, "I was unable to locate non-pharmacological intervention prior to the administration of Resident #1's prn Tylenol." The facility administration was informed of the finding during a briefing on 11/17/17 at approximately 2:30 p.m. The facility did not present any further information about the findings.	F 309		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 314		12/25/17

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F 314	Continued From page 24 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews and review of the facility documentations, the facility failed ensure the necessary treatment was provided to prevent infection and promote healing for 1 of 16 Residents (Resident #1) in the survey sample. The facility staff failed to ensure infection control practice were followed during a sacral wound *stage 2 *pressure ulcer dressing for Resident #1. The findings included: Resident #1 was admitted to the facility on 08/18/17. Diagnosis for Resident #1 included but are not limited to Right *femur fracture and *Anemia. The current Minimum Data Set (MDS) a 30-day assessment with an Assessment Reference Date (ARD) of 09/15/17 coded the resident with a 08 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #1 requiring total dependence of one with bathing, extensive assistance of two with transfers and mobility, extensive assistance of one with dressing, hygiene and toilet use, and limited assistance of one with eating. Resident #1 was coded frequently incontinent of bowel and	F 314	Prefix Tag: 314 Treatment/Services to Prevent/Heal Pressure Sores CFR(s): 483.25(b)(1) It is the intent of this facility to ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. Upon discovery, the nurse was immediately counselled for not following proper infection prevention procedures during provision of wound care, including washing hands and proper use of gloves before, during and after wound care. This nurse did not perform any other wound care until 11/17/17, under the direct supervision of the DON, when the proper infection prevention procedures were demonstrated successfully.	

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F 314	Continued From page 25 bladder. In section "M" (Skin Conditions) of MDS 09/15/17 coded Resident #1 at risk for developing pressure ulcers, having a stage 1 or higher. Resident #1 was also coded 0 if resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher. *Pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) . *Pressure Injury - Stage 2 (Partial-thickness skin loss with exposed dermis_ Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds	F 314	2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: All licensed nurses received training on the proper procedures for infection prevention by the DON, including handwashing and proper use of gloves, before, during, and after wound care, by November 21, 2017. The Administrator and/or DON spoke with each licensed nurse to review and reinforce proper infection prevention procedures. All other direct care staff received training by November 25, 2017, from the DON and Nurse Manager.. All other staff members working within this area received education, from Staff Development RN, at the All Staff Meeting. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. DON or Nurse Manager will monitor handwashing daily each shift for one month; then monitor daily random shifts for 3 months; weekly for 4 months; and monthly for 4 months. Physical observations were added to the Weekend Managers monitoring checklist and to the DON and Charge Nurse QAPI checklists, for review by the QAPI Committee. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality	

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F 314	Continued From page 26 (skin tears, burns, abrasions (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ *Right femur fracture is a hip fracture is a break in the upper part of the thigh bone(femur) where the thighbone joins the pelvis to form the hip joint (www.webmd.com/osteoporosis/hip-fracture). *Anemia is condition when blood does not carry enough oxygen to the rest of your body (Source: NIH U.S. National Library of Medicine: Medline Plus). Resident #1's care plan documented Resident #1 at risk for impaired skin integrity related to impaired mobility, incontinence and poor tissue perfusion. The goals: the resident will remain free of skin breakdown over the next 90 days. Some of the interventions include but not limited to: Pressure reducing mattress, check skin for redness, skin tears, swelling, or pressure areas. Report and signs of skin breakdown. The current treatment as of 11/10/17 is to cleanse sacrum with normal saline, apply barrier ointment, apply *mepilex foam pad, cover with mepilex dressing, off load area when every possible and change daily until resolved. *Mepilex is a foam dressing suitable for a wide range of wounds like venous leg ulcers, pressure ulcers or diabetic ulcers (www.molnlycke.us/advanced-wound-care-products/foam-dressings/mepilex/). On 11/15/17 at approximately 10:00 a.m., the resident was observed lying in bed on a specialty mattress; in a supine position. LPN #2 performed	F 314	assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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wound care with the assistance of LPN #3. Both LPN's washed her hands then donned a pair of gloves prior to starting sacral wound care dressing change, LPN #2 removed the dressing from the sacral wound, placed the soiled dressing inside a clear plastic bag, removed her gloves then went into the bathroom, got a pair of clean gloves from the glove holder on the bathroom wall, donned the new gloves, returned to the bedside, proceeded to clean the wound with normal saline, applied barrier cream to the wound followed with mepilex the covered with a foam dressing.

On 11/15/17 at approximately 2:35 p.m., and interview was conducted with LPN #2 who stated, "I should have removed my gloves after I removed the soiled dressing, washed my hands then put on another pair of gloves, cleaned the wound, remove my gloves, finish wound care then wash may hands again.

An interview was conducted with the Director of Nursing (DON) on 11/16/17 at approximately 11:20 a.m., who stated, "The nurse should have washed her hands before starting wound care, after removing the soiled dressing, remove gloves, wash hands, donned a new pair of gloves, clean the wound, remove gloves, wash hands again then put on another pair of gloves.

The facility administration was informed of the finding during a briefing on 11/16/17 at approximately 2:30 p.m. The facility did not present any further information about the findings.

The facility's policy: Skin Care - Wound Care (Revised 10/22/14)

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Policy Statement:
-The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.

Policy Interpretation and Implementation
-This procedure may involve potential and/or direct exposure to blood, body fluids, infectious diseases, air contaminants, and hazardous chemicals.

Steps in the Procedure include but not limited to:

-Wash your hands thoroughly before beginning the procedure.
-Tape plastic bag to bedside table for waste. Clean bedside table with chemical wipe.
-Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. Wash hands or use hand sanitizer.
-Use new, clean gloves. Loosen tape and remove dressing.
-Pull glove over dressing and discard both into appropriate receptacle. Wash hands or use hand sanitizer.
-Use new, clean gloves.
-Pour liquid solutions directly on gauze sponges on their papers.
-Use new, clean gloves for holding gauze to catch irrigation solutions that are poured directly over the wound.
-Clean wound as ordered. Discard gloves. Wash hands or use sanitizer.
-Use new, clean gloves. Apply treatment as indicated.
-Dress wound as ordered.
-Place barrier cloth and soiled items into designated container. Remove gloves and

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F 314	Continued From page 29 discard into designated container. Wash your hands. -Use new, clean gloves. Clean over bed table with chemical wipe. -Wash your hands.	F 314		
F 323 SS=D	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 appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility documentation review the facility staff failed to	F 323	Prefix Tag: 323 Free of Accident Hazards/Supervision/Devices CFR(s):	12/21/17

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F 323	Continued From page 30 ensure one treatment cart was stored in a secured location, accessible to designated staff only. The facility staff failed to ensure treatment cart containing medication in the hallway was locked when not in direct site of the nurse. The findings include: On 11/15/17 at approximately 9:55 a.m., LPN #2 removed wound care supplies from the back hall treatment cart located in the hallway; then went into room 538B to perform wound care on Resident #1. At approximately 10:15 a.m., the surveyor came out of the room and noticed the treatment cart was left unlocked. The nurse came out of room 538, walked pass the unlocked treatment cart over to the medication cart. The surveyor informed the LPN that she had left her treatment cart unlocked after she had removed wound supplies. The surveyor asked, "Should your medication cart have been locked with not in direct site, the LPN stated, "My cart should have locked my cart." An interview was conducted with the Director of Nursing (DON) on 11/15/17 at approximately 11:25 a.m., who stated, I expect for all nurses to lock their treatment and medication cart when not in direct view of the nurse. The facility administration was informed of the finding during a briefing on 11/17/17 at approximately 2:30 p.m. The facility did not present any further information about the findings. The facility's policy: Medications - Storage of Medications (Revised 09/18/15).	F 323	483.25(d)(1)(2)(n)(1)-(3) It is the intent of this facility to ensure that the resident environment remains as free from accident hazards as is possible and each resident receives adequate supervision, to include ensuring treatment carts are stored in a secured location, accessible to designated staff only, and treatment carts on hallways containing medications are locked when not in direct site of the nurse. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. Upon discovery, the cart was locked and the nurse was immediately counselled regarding her failure to maintain a locked treatment cart when it is out of eyesight and provided one-on-one training to emphasize the risks associated with leaving carts unlocked and accessible to our residents. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: All nurses were verbally instructed by the DON and Nurse Manager and returned a written acknowledgement of the expectation that the treatment cart is secure at all times when not in eye sight of the nurse. Completed 11/21/17. 3) Measures to be put into place or systemic changes made to ensure that	

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F 323	Continued From page 31 Policy Statement: The purpose of this procedure is to ensure that medications are stored in a safe, secure, and orderly manner.	F 323	the alleged deficient practice will not occur. The DON and Nurse Manager, will observe the location and security of the treatment cart when in use. Location and security will be monitored daily for two weeks; weekly for six months; then randomly for six months. The QAPI checklists for DON and Charge Nurse, and the Weekend Managers Checklist were revised to include the observation of treatment carts. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		11/17/17

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F 371	Continued From page 32 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility staff failed to store and prepare food with professional standards for food service safety. The findings included: During the initial kitchen tour on 11/14/17 at 12: 18 P.M. An uncovered bowl of cake mix, with blender blades which had cake mix on them were observed on a cart. In the ice cream freezer two of four five gallon ice cream containers had lids inside the ice cream containers touching the ice cream.. There was one un-covered bowel of Cole slaw observed sitting on the serving line. There were four uncovered bowls of berry's observed sitting on the serving line. One bag of puree turkey sausage was observed sitting on top of a	F 371	Prefix Tag: F371 Food Procure, Store/Prepare/Serve/Sanitary CFR(s): 483.60(i)(1)-(3) It is the intent of this facility to store and prepare food with professional standards for food service safety. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. No residents of the nursing facility were affected by any identified deficient practice identified in the report because none of the food items noted on this report were served to any resident in the nursing facility on the campus of this	

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F 371	Continued From page 33 tray of bacon on a food cart in the middle of the floor leading into the refrigerator. A review of the menu for November 14, 2017 indicated: Cole slaw was to be served during the lunch meal and a mixed berry salad was to be served during the dinner meal.. A Dietary Food Storage Policy indicated: "Food storage areas shall be maintained in a clean, safe and sanitary manner. 3. Cold foods shall be maintained at temperatures of 40 degrees or below. 5. All foods stored in walk-in refrigerators and freezers shall be stored in the kitchen area or in storerooms for food or food preparation. The Dietary Manager stated during the tour on 11/14/17 at 12: 24 P.M. that new ice cream container tops were on order. A dietary aide stated, The cake mix was to be discarded.	F 371	CCRC. All food items on the menu were recorded by facility staff at appropriate temperatures prior to serving. All of the items noted on this report were addressed during the normal operating routine of this kitchen. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: No residents of the nursing facility were affected by any identified deficient practice identified in the report because none of the food items noted on this report were served to any resident in the nursing facility on the campus of this CCRC. All food items on the menu were recorded by facility staff at appropriate temperatures prior to serving. All of the items noted on this report were addressed during the normal operating routine of this kitchen. On 11/16/17 the dietary staff reviewed the procedures as they relate to serving in the Independent Living Main Dining Room from the nursing facility serving line; disposing of extra products after pie shells were filled; assuring compliance with the menu for nursing facility residents; storage of ice cream for the Independent Main Dining Room; and storage of uncooked products in the walk in refrigerator. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur.	

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F 371	Continued From page 34	F 371	Dietary Manager and Chef will observe and monitor for compliance pertaining to storing and preparing food with professional standards for food service safety. Logs for the following will continue to be completed by line staff and reviewed audited by the Dietary Manager. Monitoring Sheet for Dietary Cooks Discarded Cart; Monitoring Sheet for Dietary Ice Cream Lids; Monitoring Sheet for Dietary Cooks Prep Cart; Monitoring Sheet for Dietary Cooks Cold Items. By November 17, 2017. Signage placed above the ice cream freezer indicating that the ice cream is for the Independent Living Dining Only and instructing staff to not serve to residents in the nursing facility. A sign will be placed above the serving line identifying it as the Independent Living Serving Line. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the Dining Services Manager with oversight by the Administrator through the QAPI process. The Administrator will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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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 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,	F 441		11/21/17

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F 441	Continued From page 36 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, resident interview, staff interview, facility documentation review, clinical record review,the facility staff failed to: 1. The facility staff failed to ensure infection control measures of hand hygiene and allowing santi wipe to dry for a full 2 minutes were followed during a glucometer check to prevent potential infections for 1 Resident (Resident #14) in the survey sample of 14 Residents.	F 441	Prefix Tag: F441 Infection Control, Prevent Spread, Linens CFR(s); 483.80(a)(1)(2)(4)(e)(f) It is the intent of this facility to maintain an effective infection prevention and control program which includes procedures for proper hand hygiene and cleaning/disinfecting equipment and devices. 1) Corrective action to be accomplished	

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F 441	Continued From page 37 2. The facility staff failed to implement appropriate hand hygiene during a sacral wound care dressing change in addition to disinfect the over bed table after being used for wound care for Resident #1 in the survey sample of 14 Residents. The findings included: 1. Resident #14 was admitted to the facility on 11/6/17. Diagnoses for Resident #14 included but are not limited to Diabetes Mellitus*(1). Resident #'s Initial Minimum Data Set (MDS - an assessment protocol) had not been completed. Resident #14 was observed on 11/15/17 at approximately 5:00 p.m. to require the assistance of one staff member for transfers. Resident #14 was alert and oriented to name only at this time. Resident #14's 11/8/17 to present active/current Care Plan documented the following: Problem: Risk for unstable blood glucose levels Interventions included but were not limited to: Monitor for signs and symptoms of hypoglycemia and hyperglycemia Resident #14's 11/9/17 Physician order documented the following: Humalog 100 unit/milliliter subcutaneous solution (slide scale) two times a day 2 Units Blood Sugar is 251-300 4 Units Blood Sugar is 301-350 6 Units Blood Sugar is 351-400	F 441	for those residents to have been affected by the alleged deficient practice. The glucometer for Resident #14 was retrieved and cleaned according to the manufacturer's recommendations for cleaning a glucometer and cleaning the covered surface. Resident #14 was monitored by the licensed nurses for ten days and there were no signs/symptoms of infection or illness reported. Resident #1 bedside table was disinfected and cleaned. There were no signs/symptoms of infection were reported after ten days of monitoring by licensed nurses. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: All glucometers were observed by the DON for signs of failure to be cleaned adequately. All bedside tables were observed, by the DON for signs of defective cleaning. In order to assure no other residents would be affected by these practices, all nurses were provided education by the DON and Nurse Manager, on th proper techniques of handwashing and cleaning surface areas after wound care, as well as, cleaning glucometers following the manufacturer's recommendations for cleaning. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur The weekend Managers Checklist for	

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F 441	Continued From page 38 8 Units Blood Sugar is 401-450 During an observation of medication pass on 11/14/17 at approximately 5:14 p.m., LPN (Licensed Practical Nurse) #1 was observed preparing to obtain a blood sugar check on Resident #14. LPN #1 was observed to wash her hands for approximately 20 seconds. LPN #1 then walked to her equipment that she had placed on a paper towel on Resident #14's table and donned non sterile gloves. LPN #1, wiped down the glucometer meter with a disinfecting wipe and immediately walked to Resident #14's bed. LPN #1, explained to the Resident that she was going to obtain a finger stick for blood and asked if it was ok. LPN #1, wiped Resident #14's finger tip with an alcohol pad and used a lancet to prick Resident #14's finger tip. As LPN #1 went to place the drop of blood on the glucose strip, she stated, "Oh, I didn't cut the machine on, I'll have to do this again. LPN #1 removed her gloves and washed her hands for approximately 10 seconds. LPN #14 donned clean gloves and wiped Resident #14's finger tip with alcohol and this time dried finger tip with paper towel. LPN #14 cut glucometer on and inserted strip into the meter. LPN #14 then using a lancet pricked Resident #14's finger tip, obtained a drop of blood, wiped the first drop away using a paper towel and applied the second drop of blood to the glucose strip. The results read 140. LPN #1 stated, "He will not get insulin coverage as he is under 251." LPN #1 removed her gloves and then washed her hands for approximately 20 seconds. The Facility Policy and Procedure, titled, "Personal Protective Measures Handwashing" with a revision date of 6/23/16, documented the	F 441	monitoring, and the QAPI checklists for the DON and Charge Nurse QAPI were updated to include observation in these areas, for review by the QAPI Committee. An additional monitoring tool was developed to assure compliance with accucheck competency to be monitored by the DON. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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following:

Appropriate handwashing must be performed for a minimum of 20 seconds under the following conditions:
Before performing invasive procedures
Before preparing or handling medications
After contact with blood,
After removing gloves

The Facility provided a one page documented (page 55), titled, "Infection Prevention and Control Manual for Long Term Care" from Patient Care Guidelines. It documented the following: The meter will be disinfected after each use, according to the manufacturer's instructions. Visible debris will be removed with soap and water prior to disinfection. The glucometer will be disinfected with Sani-wipes containing a hypochloric solution.

The Facility provided a copy of the printed information on the Sanitizing wipes container that LPN #1 used to clean the glucometer. It documented the following:

TO DISINFECT AND DEODORIZE: To disinfect nonfood contact surfaces only; Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two (2) minutes. Let air dry. For heavily soiled surfaces sue a wipe to pre-clean prior to disinfecting.

The Center for Disease Control (https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines.pdf) Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 documented the following:

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The choice of disinfectant, concentration, and exposure time is based on the risk for infection associated with use of the equipment and other factors discussed in this guideline.

However, for these processes to be effective, health-care workers should adhere strictly to the cleaning, disinfection, and sterilization recommendations in this document and to instructions on product labels.

Disinfection describes a process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects (Tables 1 and 2). In health-care settings, objects usually are disinfected by liquid chemicals or wet pasteurization. Each of the various factors that affect the efficacy of disinfection can nullify or limit the efficacy of the process.

Interview:----------

The facility administration was informed of the findings during a briefing on 11/14/17 at approximately 2:26 p.m. The facility did not present any further information about the findings.

Definitions:

1. Diabetes Mellitus: Medline Plus documented: Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose comes from the foods you eat. Insulin is a hormone that helps the glucose get into your cells to give them energy. With type 1 diabetes, your body does not make insulin. With type 2 diabetes, the more common type, your body does

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not make or use insulin well. Without enough insulin, the glucose stays in your blood. You can also have prediabetes. This means that your blood sugar is higher than normal but not high enough to be called diabetes. Having prediabetes puts you at a higher risk of getting type 2 diabetes.

2. The facility staff failed to implement appropriate hand hygiene during a sacral wound *stage 2*pressure ulcer dressing change in addition to disinfect the over bed table after being used for wound care for Resident #1.

Resident #1 was admitted to the nursing facility on 08/18/2017. Diagnosis for included but not limited to Right *femur fracture.

The current Minimum Data Set (MDS) a 30-day assessment with an Assessment Reference Date (ARD) of 09/15/17 coded the resident with a 08 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #1 requiring total dependence of one with bathing, extensive assistance of two with transfers and mobility, extensive assistance of one with dressing, hygiene and toilet use, and limited assistance of one with eating. Resident #1 was coded frequently incontinent of bowel and bladder.

In section "M" (Skin Conditions) of MDS 09/15/17 coded Resident #1 at risk for developing pressure ulcers, having a stage 1 or higher. Resident #1 was also coded 0 if resident have one or more unhealed pressure ulcer (s) at Stage 1 or higher.

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*Pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

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

*Right femur fracture - a hip fracture is a break in the upper part of the thigh bone (femur) where the thigh bone joins the pelvis to form the hip joint (www.webmd.com/osteoporosis/hip-fracture).

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Resident #1's care plan documented Resident #1 at risk for impaired skin integrity related to impaired mobility, incontinence and poor tissue perfusion. The goals: the resident will remain free of skin breakdown over the next 90 days. Some of the interventions include but not limited to: Pressure reducing mattress, check skin for redness, skin tears, swelling, or pressure areas. Report and signs of skin breakdown.

The current treatment as of 11/10/17 is to cleanse sacrum wound with normal saline, apply barrier ointment, apply *mepilex foam pad, cover with mepilex dressing, off load area when every possible and change daily until resolved.

*Mepilex is a foam dressing suitable for a wide range of wounds like venous leg ulcers, pressure ulcers or diabetic ulcers (www.molnlycke.us/advanced-wound-care-products/foam-dressings/mepilex/).

On 11/15/17 at approximately 10:00 a.m., the resident was observed lying in bed on a specialty mattress; in a supine position, resident was position to his left side with assistance of LPN #3. LPN #2 placed a clear plastic bag over the over bed table as the table barrier then placed all wound care supply items on the plastic bag covering the over bed table. LPN #2 performed wound care with the assistance of LPN #3. LPN #2 removed the dressing from the sacral wound, placed the soiled dressing inside a clear plastic bag, removed her gloves, went into the bathroom, got a pair of clean gloves from the glove holder on the bathroom wall, donned the new gloves, returned to the bedside, proceeded to clean the wound with normal saline, applied barrier cream

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to the wound followed with mepilex the covered with a foam dressing. The wound nurse washed her hands using soap x 10 seconds then put her hands under the running water, rinsing off all the soap but continued to rub her hands together for 5 minutes. LPN #2 removed the clean plastic bag from the over bed table and dispose in the trash can. The surveyor if she was finished with completing her wound care, she replied, "Yes I'm done, then walked out the room."

On 11/15/17 at approximately 2:15 p.m., and interview was conducted with LPN #2 who stated, "I should have removed my gloves after I removed the soiled dressing, washed my hands then put on another pair of gloves, cleaned the wound, remove my gloves, finish wound care then wash may hands again. The surveyor asked if the over bed table should have been disinfected after use, she replied "No, I don't see why, I put the supplies in the plastic bag covering the table, the table was never touch, so I had no reason to clean it." The surveyor then asked, "How long do you wash your hands after wound care, she replied "20 seconds, the surveyor informed LPN #2, she actually washed her hands using soap x 10 seconds then put her hands under the running water, rinsing off all the soap but continued to rub her hands together for 10 minutes with just water.

An interview was conducted with the Director of Nursing (DON) on 11/16/17 at approximately 11:20 a.m., who stated, "The nurse should have washed her hands before starting wound care, after removing the soiled dressing, remove gloves, wash hands, donned a new pair of gloves, clean the wound, remove gloves, wash hands again then put on another pair of gloves. The

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DON also stated, "After removing the supplies from the over bed table, she should have clean the over bed table also."

The facility administration was informed of the finding during a briefing on 11/17/17 at approximately 2:30 p.m. The facility did not present any further information about the findings.

The facility's Policy - Personal Protective Measures - Handwashing (Last Revision - 6/23/16).

Policy Statement
-The purpose of this procedure is to provide guidelines to employees for proper and appropriate handwashing techniques that will aid in the prevention of the transmission of infections.

Policy Interpretation and Implementation (Objectives)
-To prevent the spread of infectious diseases.

When to Wash Hands:

Appropriate handwashing must be performed for a minimum of 20 seconds under the following conditions include but not limited to:
- After having prolonged contact with resident.
-After handling used dressings, specimen's containers, contaminated tissues, linen, etc.
-After contact with blood, body fluids, secretions excretions, mucous membranes, or broken skin.
-After handling potential contaminated with a resident's blood, body fluids, excretions or secretions.
After removing gloves

Procedure Guidelines:

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F 441	Continued From page 46 -Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds under a moderate stream of water, at a comfortable temperature.	F 441		
F 465 SS=F	SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON CFR(s): 483.90(i)(5) (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews, the facility staff failed to provide a safe, sanitary and comfortable environment. The findings included: During the General Observations of the environment on 11/16/17 at 11:14 A.M. the following areas were noted: In the shower room an old battery charger was observed on the floor the shower. The shower room floor drain was observed to have trash and debris. In the Electrical Room that also housed the copier and fax machine was observed paper. trash and debris on the floor.	F 465	Prefix Tag: F 465 Safe/Functional,Sanitary/Comfortable Environment CFR(s) 483.90(i)(5) It is the intent of this facility to provide a safe, sanitary and comfortable environment for residents, staff and the public. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. No residents were identified in the report as being affected. During the survey, the Plant Operations Director, while on the walk-through with the surveyor, disposed of the few sheets of paper which fell	11/16/17

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F 465	Continued From page 47 In the Mechanical Room mold and mildew like substance was observed on the vent cover of an air duct. The Maintenance Director stated, "the air goes all over the residential area." In the Soiled Utility Room a 2 x 3 foot board was observed sitting on top of a small refrigerator used for storing laboratory samples. In the Medication storage room dead bugs and cob webs were observed on the counter where the Stat Medication box was stored. The light bulbs in the Laundry chemical storage room were not functioning. The outside Bi-Hazard Room was observed to have trash and debris. There were two old container tops used to cover laundry carts stored in the room. Two five gallon containers of sand with cigarette butts were observed in the room along with an old cigarette snuffer. During an interview with the Maintenance Director he stated, some areas are to be cleaned on a routine bases and others on a monthly schedule. The facility staff failed to provide a safe, sanitary and comfortable environment.	F 465	behind the FAX machine in the electrical room. The battery charger was removed and the shower room drain was cleared of trash/debris and cleaned. The maintenance staff removed and cleaned the one vent identified in the mechanical room. The board was removed from the dirty utility room. The Plant Operations Director had also removed the two bugs in the dirty utility room. The light bulb in the storage closet was replaced immediately. The items in the outdoor storage closet items were removed, although they were not impeding on the space of the medical waste area. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: No residents were affected. The Director of Plant operations conducted an inspection of the nursing facility and did not identify any additional problems with misplaced equipment and items, burned out lights or dirty vents. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Nursing and administrative staff will monitor the FAX area, dirty utility and bathroom areas next to the nurses station for cleanliness. Staff will notify the appropriate department when the need arises. A maintenance log will be	

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F 465	Continued From page 48	F 465	completed monthly to assure there are no current lighting issues; an HVAC log will be reviewed, by the Plant Operations Director each month to assure vents are clean. We will continue with our Pest Control Contract and current plan. The QAPI audit tool for Plant Operations addresses measures to monitor in order to maintain a safe, sanitary and comfortable environment. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the Plant Operations Director with oversight by the Administrator through the QAPI process. The Plant Operations Director will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
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	F 514		11/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495366	A. BUILDING _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PRINCE WOODS, INC	100 ANNA GOODE WAY SUFFOLK, VA 23434

(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 514	Continued From page 49 are- (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 observation, resident interview, staff interview and facility documentation review the facility staff failed to ensure a complete and accurate clinical record for 1 of 16 residents (Resident #1) in the survey sample. The facility staff failed to ensure the Treatment Administration Record (TAR) for November 2017 was accurate for the application of *ted hose for	F 514	Prefix Tag: 514 Resident Records Complete/Accurate/Accessible CFR(s): 483.70(i)(1)(5) It is the intent of this facility to assure a complete and accurate Treatment Administration Record is maintained for the application of TED hose. 1) Corrective action to be accomplished	

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F 514	Continued From page 50 Resident #1. The findings include: Resident #1 was admitted to the nursing facility on 08/18/2017. Diagnosis included but not limited to Right *femur fracture. The current Minimum Data Set (MDS) a 30-day assessment with an Assessment Reference Date (ARD) of 09/15/17 coded the resident with a 08 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. *Ted hose are stockings that help prevent blood clots and swelling in your legs (https://www.drugs.com/cg/ted-hose.html). *Right femur fracture - a hip fracture is a break in the upper part of the thigh bone (femur) where the thigh bone joins the pelvis to form the hip joint (www.webmd.com/osteoporosis/hip-fracture). On 11/14/17 at 12:20 p.m., during the initial tour, Resident #1 was observed lying in bed with his left leg hanging off the side of the bed; ted hose was not present to left lower extremity. During the review of Resident #1's Treatment Administration Record (TAR) on 11/14/17 at approximately 2:15 p.m., indicated the following order written on 08/28/17: ted hose to be donned in A.M. (morning) and removed every H.S. (night). On the same day at approximately 3:30 p.m., Resident #1 was sitting on the side of the bed without ted hose to bilateral lower extremities. The review of November 2017 Treatment Administration Record (TAR), the nurse had	F 514	for those residents to have been affected by the alleged deficient practice. On 11/14/17, the Nurse responsible for placing the TEDs was provided one-on-one re-education for not completing documentation regarding the application of the TED hose. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: On 11/14/17 the DON and Administrator reviewed the TAR orders for all residents with TED hose. Each resident was visually observed wearing their TED hose as ordered and consistent with documentation on the TAR. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. By November 21, 2017, all nurses and direct care staff received training by the DON and Nurse Manager on all residents' treatment orders for TED hose to ensure orders are being followed consistently and documented accordingly. A TED Hose monitoring tool will be used to monitor by shift, daily and weekly compliance of TED hose orders and applications. The MDS Coordinator reviews the list weekly to reconcile residents listed on check list and verify with orders. Monitoring of TED hose has been added to the Weekend	

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F 514	Continued From page 51 signed off on 11/14/17 that Resident #1's ted hose had been applied. An interview was conducted with Resident #1 on 11/14/17 approximately 3:30 p.m., the surveyor asked if his ted hose had been applied to his lower extremities today, he replied "No, they haven't been on at all today." On 11/14/17 at approximately 5:00 p.m., Resident #1 was in the dining room waiting for his dinner tray. The surveyor observed the resident was not wearing his ted hose. On the same day at 5:20 p.m., the surveyor and the Director of Nursing (DON) walked to the dining room; the DON observed Resident #1 was not wearing his ted hose then stated, "I expect for the nurse to follow physician orders as they are written and to call the physician in advance why the resident is not wearing his ted hose." The surveyor asked if Resident #1 has edema to his lower extremities, she replied, "Yes, that's more reason for him to have his ted hose on." The facility administration was informed of the finding during a briefing on 11/17/17 at approximately 2:30 p.m. The facility did not present any further information about the findings. The facility's policy: Charting (Revised 02/28/17). Policy Statement: -All services provided to the resident, or any changes in the resident's condition, she be recorded in the resident's medical record. Policy Interpretation and Implementation: -Entries must be recorded by the person rendering the service just after it was performed.	F 514	Manager Rounding Sheet, and the QAPI checklists for the DON and the Charge Nurse. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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F 514	Continued From page 52 -All unanticipated occurrences or changes in the resident's condition must be recorded.	F 514		