Iliff
Nursing and Rehabilitation Center
Genesis HealthCare®
8000 Iliff Dr.
Dunn Loring, VA 22027
Tel 703-560-1000

May 12, 2016

Ms. Elaine Cacciatore, Long Term Care Supervisor
Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive, Suite 401
Richmond, Virginia 23233

Dear Ms. Cacciatore,

Please find the enclosed response to the deficiencies the staff from the Virginia Department of Health's Office of Licensure and Certification identified during the unannounced standard survey ending April 28, 2016.

Iliff Nursing and Rehabilitation Center respectfully requests that this plan of correction and the compliance dates contained herein be considered as the facility's credible allegation of compliance.

If you should have any further questions please feel free to contact me at 703-560-1002.

Sincerely,

Kathy Delimba
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495205	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILIFF NURSING HOME AND REHAB C	8000 ILIFF DRIVE DUNN LORING, VA 22027

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F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State licensure inspection was conducted 4/26/16 through 4/28/16. Significant corrections were required and corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. A Past-Non Compliance deficiency was cited at a harm level at F323. The Life Safety Code Survey/Report will follow. The census in this 130 certified bed facility was 103 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents #1 through #18), and 5 closed records (Residents # 19 through #23).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: COV 12 VAC 5-371-200 (E, F.1) Based on staff interview, facility documentation review, and employee record review, the facility staff failed to ensure verification of one CNA (certified nursing assistant) Emp. #24) certification with DHP (Department of Health Professions) out of a survey sample of 22 certified/licensed employees. Emp. #24 was hired on 10/9/15 and no license verification was obtained from DHP until 4/27/16. The findings included:	F 001	RECEIVED MAY 13 2016 VDH/OLC **COV 12 VAC 5-371-200 (E, F.1)** **1. Corrective Action** **The license verification with the Department of Health Professions of employee # 24 was done on April 27, 2016 and no residents were affected by this deficient practice.** **2. Other Potential Residents** **All residents have the potential to be affected by this deficient practice.**	

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F 001	Continued From Page 1 Emp. #24, a CNA was hired by the facility 10/9/15. Upon hire, she was determined to have just graduated from a CNA program. A thorough review of Emp. #24's employee file revealed no certification had been obtained through DHP as of 4/27/16. Other A, the human resources manager stated 4/27/16 at 3:17 p.m. at she would review the issue and check to see if certification verification for Emp. #24 was in another file. A certification verification through DHP was presented 4/27/16 at 4:10 p.m. and Other A stated she was unable to find the certification had been verified prior to 4/27/16. Review of the policy entitled, "VA (Virginia) Abuse Prohibition-State of Virginia" included: "The Center will screen potential employees for a history of abuse, neglect, or mistreating residents including checking with appropriate licensing boards and registries. 2.1 The Center will not employ individuals who: 2.1.1 Have been found guilty by a court of law of abusing, neglecting, or mistreating others; or 2.1.2 had a finding entered into the state nurse aid registry concerning abuse, neglect, mistreatment of others or misappropriation of property..." The administrator, DON (director of nursing), and corporate consultant were informed of the failure of the staff to verify certification with DHP for Emp. #24, 4/28/16 at 1:15 p.m. The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities:	F 001	**3. New Measures/Systems Change** **The Administrator will re-educate the business office staff on the importance of having all employee licenses verified with the Department of Health Professions.** **The facility Business Office Manger audited 100% of all current licensed employee files and found all licenses were verified with the Department of Health Professionals. This audited was completed May 5, 2016.** **4. Monitoring** **The facility Business Office Manager will audit 100% of all newly hired employees over the course of the next three months to ensure all the newly hired employees have their license verified through the Department of Health Professionals. The Business Office Manager will present her findings of these audits monthly to the Administrator and the CQI Committee.** **5. Completion Date** **June 11, 2016.** RECEIVED MAY 13 2016 VDH/OLC	

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F 001	Continued From Page 2 Resident Assessment and Care Plan 12 VAC 5-371-250 (B.2) Cross-Reference to F-274 Nurse Staffing 12 VAC 5-371-210 (E, F.1) Nursing Services 12 VAC 5-371-220 (B) Cross-Reference to F-329 12 VAC 5-371-220 (C) Cross-Reference to F-309 Pharmaceutical Services 12 VAC 5-371-300 (B) Cross-Reference to F-425 and F431 Dietary and Food Service Program 12 VAC 5-371-340 (J) Cross-Reference to F-367 Clinical Records 12 VAC 5-371-360 (E) Cross-Reference to F-514	F 001	Resident Assessment and Care Plan 12 VAC 5-371-250 (B.2) --See response for F-274 on pages 3 & 4 of 40. Nurse Services 12 VAC 5-371-220 (B) –See response for F-329 on pages 16, 17, & 18 of 40. 12VAC 5-371-220 (C) -See response for F-309 on pages 5 & 6 0f 40. Pharmaceutical Services 12 VAC 5-371-300 (B) –See response for F-425 on page 32 of 40 and F-431 on pages 35 & 36 of 40. Dietary and Food Services Program 12 VAC 5-371-340 (J) – See response for F-367 on pages 23 & 24 of 40. Clinical Records 12 VAC 5-371-360 (E) –See response for F-514 on pages 37 & 38 of 40.	

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/26/16 through 4/28/16. Significant corrections were required and corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. A Past-Non Compliance deficiency was cited at a harm level at F323. The Life Safety Code Survey/Report will follow. The census in this 130 certified bed facility was 103 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents #1 through #18), and 5 closed records (Residents # 19 through #23).	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, facility documentation review, and staff interview, the facility staff failed to ensure signage was available to indicate the location of previous federal surveys. No signage was evident to indicate the location of previous surveys.	F 167	RECEIVED MAY 13 2016 VDH/OLC **F – 167** **1. Corrective Action** **On April 27, 2016 new signage was posted stating the location of the most current survey results and the location of the previous survey results. No residents were affected by this deficient practice.** **2. Other Potential Residents** **All residents had the potential to be affected by this deficient practice.** **3. New Measures/Systems Change** **New signage was posted stating the location of the most current survey results and the location of the previous survey results on April 27, 2016.**	

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

[signature] LNHA 5/12/16

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

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F 167	Continued From page 1 The findings included: During general observation of the facility, a sign was observed 4/27/16 at 11:18 a.m. The sign stated: "This center has reports of surveys, certifications and complaint investigations for the preceding three years available for any individual to review upon request. Please see the administrator to inquire." The sign was in a holder on a table in the front lobby. A binder was sitting to the left of the sign, along with a number of other binders, containing the survey results. Additionally, the sign had the name of the new owners of the facility, as the facility had changed ownership at the beginning of 2016. The administrator was unaware of the need to have the location of the survey results posted, 4/27/16 at end of day survey. The administrator, DON (director of nursing), and corporate consultant were informed of the failure of the facility to have signage indicating the location of previous surveys, 4/28/16 at 1:20 p.m.	F 167	**4. Monitoring** **The Administrator or designee will visually observe to ensure the new sign posted stating the location of current and previous survey results remains in place. These observations will occur a minimum of five days per week over the next three months and a report of the findings will be prepared and presented monthly to the CQI Committee.** **5. Completion Date** **June 11, 2016.**	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change	F 274		

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F 274	Continued From page 2 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on Family interview, staff interview, clinical record review and facility documentation review, the facility staff failed to complete a SCSA (significant change in status assessment) within 14 days after determination of a change in status for 1 Resident (Residents #7) of the 23 residents in the resident survey sample. For Resident #7, the facility staff failed to assess the Resident for a significant change in condition after the Resident's functional status in transferring, ambulation, dressing, hygiene and toileting changed from extensive assistance, and completely dependent to Limited assistance on staff members for these Activities of Daily Living (ADL's). The findings included: Resident #7 was originally admitted to the facility on 6-9-15, and readmitted after a hospitalization on 3-8-16. Diagnoses included; Hypertension, renal insufficiency, hypothyroidism, dementia, seizure disorder, asthma, and vitamin D deficiency. Resident #7's most recent Minimum Data Set	F 274	**F – 274** **1. Corrective Action** **Residents #7 suffered no ill effects from this deficient practice.** **2. Other Potential Residents** **All residents have the potential to be affected by this deficient practice.** **3. New Measures/Systems Change** **The Administrator will re-educate the Clinical Reimbursement Coordinators (MDS Coordinators) who are responsible for completing a significant change in status assessment on the need to complete the assessment even on residents who show an improvement in status.** **The Administrator will educate all Department Managers and staff present during the monthly Administrators staff meeting on the importance of notifying the Clinical Reimbursement Coordinators (MDS Coordinators) if they feel a resident has had a significant change in status so they can determine if there is a need to complete a significant change in status assessment.**	

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F 274	Continued From page 3 (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4-5-16. The Resident was coded with a Brief interview for mental status (BIMS) score of 3 points scored in a possible 15 points, indicating severe cognitive impairment. The Resident required limited assistance of staff for transferring, ambulation, and hygiene. The Resident was also coded as requiring extensive assistance of staff for dressing, and toileting. The Most recent Full MDS assessment used for comparison, was a Significant change Assessment completed on 1-4-16, and was completed just prior to the most recent quarterly assessment mentioned above. The changes experienced by Resident #7 between these two assessments follow below: 1-4-16 Significant Change assessment = The Resident required extensive assistance of staff for transferring, and ambulation, and was totally dependant on staff for dressing, hygiene, and toileting. 4-5-16 Quarterly assessment = The Resident required limited assistance of staff for transferring, ambulation, and hygiene. The Resident was also coded as requiring extensive assistance of staff for dressing, and toileting. Review of these documents reveals significant changes in transferring, ambulation, dressing, hygiene, and toileting between the two completed assessments, without a significant change assessment being completed as of the time of survey, which was 23 days after the quarterly assessment was completed.	F 274	**4. Monitoring** **Significant change in status will be added to the agenda of the daily team morning meetings twice weekly over the next 3 months. The team will identify any resident they feel may meet the criteria for a significant change in status assessment. If verified to meet the criteria an assessment will be completed. The Administrator or designee will verify that the significant change in status assessment was completed on all identified residents meeting criteria and present these finding to the CQI Committee monthly for the next three months.** **5. Completion Date** **June 11, 2016**	

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F 274	Continued From page 4 On 4-27-16, and 4-28-16, at the end of day debrief the Director of Nursing and the Administrator were made aware of the need for a significant change assessment, and they stated that no further documentation was available to be presented.	F 274		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed for one resident (Resident #5) of 23 residents in the survey sample to provide dementia related care and services. Resident #5 was administered the PRN (as needed) antianxiety medication Ativan, without attempting non-pharmacological interventions on 4/14/16, 4/22/16 and 4/26/16. The findings included: Resident #5 was admitted to the facility on 12/17/13 with the diagnoses of, but not limited to, dementia with behavior disturbance, psychosis, anxiety and hypertension.	F 309	**F – 309** **1. Corrective Action** **Resident #5 suffered no ill effects from this deficient practice.** **2. Other Potential Residents** **All geriatric residents receiving PRN (as needed) antianxiety medications have the potential to be affected by this deficient practice.** **3. New Measures/Systems Change** **The Director of Nursing, RN Clinical Coordinator and/or RN Supervisors will re-inservice the geriatric licensed nurses on the importance of attempting non-pharmacological inventions prior to administering a PRN antianxiety medications.**	

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F 309	Continued From page 5 The most recent Minimum Data Set (MDS) was a significant change assessment with an Assessment Reference Date (ARD) of 3/31/16. The MDS coded Resident #5 with severe cognitive impairment; required assistance from staff for all activities of daily living; had physical and verbal behaviors directed toward others and "other" behaviors not directed toward others. On 4/27/16 at 9:15 a.m., Resident #5 was observed walking independently in her room. She was alert and answered questions with rambling words. No behaviors were observed at the time and Resident #5 thanked the surveyor for visiting. Review of Resident #5's clinical record, conducted on 4/27/15, revealed physician's orders which included: "Lorazepam (Ativan) Tablet 0.5 MG (milligrams) Give 1 tablet by mouth every 8 hours as needed for Anxiety." The Medication Administration Record (MAR) for April 2015 was reviewed and revealed the Ativan was administered on 4/1/16 x 2, 4/5/16, 4/8/16, 4/12/16, 4/14/16, 4/22/16 and 4/26/16. Behaviors and non-pharmacological approaches (i.e. redirection, diversional activity) were documented in the clinical record and on the Behavior Monitoring and Interventions sheet prior to administering the medication on 4/1/16, 4/5, 4/8, and 4/12/16, however there were no documented behaviors or interventions found in the clinical record or on the behavior sheet for 4/14/16, 4/22/16 or 4/26/16. Resident #5's care plan included: -Resident has hx (history) of depression, delirium,	F 309	**4. Monitoring** **The RN Clinical Coordinator and RN Supervisors will audit 25% of the behavioral sheets for all geriatric residents receiving PRN antianxiety medications weekly to ensure a non-pharmacological invention has been attempted prior to administering a PRN antianxiety medication. This audit allows for 100% of the geriatric residents receiving PRN antianxiety medication to be audited monthly to ensure a non-pharmacological invention has been attempted prior to administering a PRN antianxiety medication. The results of these audits will be shared with the Director of Nursing who will share the findings monthly over the next three months with the Administrator and the CQI Committee.** **5. Completion Date** **June 11, 2016.**	

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F 309	Continued From page 6 anxiety and auditory hallucinations with interventions that included: Administer meds as ordered by MD (Medical Doctor); attempt to find out what's bothering the resident and make changes as needed; speak to the resident in a calm voice and call her by name. -Resident exhibits behavior: pacing and shouting up and down hallway, delusional thinking, and agitation with interventions that included: Allow resident time to vent feelings/needs; Assess and manage unmet needs such as: pain, toileting, fatigue and hunger; Document interventions and resident's response; Identify behavior triggers and reduce exposure to triggers. On 4/27/16 at 3:55 p.m. an interview was conducted with the Director of Nursing (Employee-A). When asked what he expected the nurses to do prior to administering Ativan, Employee-A stated it's "Individualized for each patient." "Have to manage behaviors first of all, when you see behavior start might give it then." Informed Employee-A of the lack of non-pharmacological interventions for the above mentioned dates. On 4/28/16 at 2:30 p.m., Employee-A stated there was "No documentation for 4/14, 4/22 or 4/26 non-pharm (pharmalogical) approaches." No further information was provided by the facility staff.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		

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F 323	Continued From page 7 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review and in the course of a complaint investigation the facility failed to safely transfer one resident (Resident #19) of 23 residents in the survey sample, causing injury resulting in harm. The facility identified, corrected/implemented and inserviced staff concerning the incident, which prevented no further incidents to occur. The deficiency was cited at a Past Non-compliance at a harm level, thus no further plan of correction is needed. 1. Resident #19 sustained lacerations to both legs during a transfer from wheelchair to bed resulting in an emergency room visit and sutures to her left leg. The findings included: 1. Resident #19 was originally admitted to the facility on 2/4/15 and readmitted after a hospitalization on 3/18/15 with the diagnoses of, but not limited to, congestive heart failure (CHF), peripheral vascular disease (PVD), chronic kidney disease-stage IV, osteomyelitis of left toes, and diabetes mellitus type 2. Resident was discharged from the facility on 4/20/15, therefore	F 323	Past noncompliance: no plan of correction required.	

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F 323	Continued From page 8	F 323		

a closed record review was conducted.

The most recent Minimum Data Set (MDS) was a Significant Change assessment with an Assessment Reference Date (ARD) of 3/25/15. The MDS coded Resident #19 with intact cognition; required extensive assistance from 2 staff members for bed mobility and transfers; did not walk in room or corridor; was dependent on staff for locomotion on and off the unit; required extensive assistance of staff for dressing, toilet use, personal hygiene and bathing. The MDS coded Resident #19 with lower extremity weakness on both sides and not steady, only able to stabilize with staff assistance during surface-to-surface transfer (transfer between bed and chair or wheelchair).

On 4/28/16 Resident #19's clinical record was reviewed. The review revealed the following Progress Notes which read:

3/9/2015 at 09:33 (9:33 a.m.) "Interdisciplinary Note" written by the Social Worker included: "...continues with skilled care, she is alert and oriented. In PT resident...transfers with sliding board with min-mod assist, non ambulatory..." A sliding board is described by www.myshepherdconnection.org as a piece of equipment that can be used if a person is not able to use their legs to complete a transfer between surfaces or if a standing transfer is not safe to perform. The board is used to make a solid "bridge" between two surfaces that a person can slide across to transfer between them.

3/12/15 at 20:51 (8:51 p.m.) "Evaluation completed.at 8.00pm 2 cna (certified nursing assistant) assist resident to bed observe resident

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bleeding from both legs during pivot transfer, writer went to room to assess observe resident bilateral lower extremity with large amount of fresh bright red blood on floor, resident sustain a skin tear to right lower leg and laceration to left lower leg during transfer from wheel chair to bed, dry dressing with pressure applied. pt (patient) was admitted on 2/4/15 with laceration to left lower leg, has a + 4 edema to bilateral lower extremities and a +3 to bilateral arms...patient has a very fragile skin, edema and is on bumex 1mg (a diuretic/fluid pill) and coumadin 4mg (an anticoagulant/blood thinner)...MD (Dr. Name) notified order to transfer resident via 911 to (Name of Hospital) for further evaluation..."

3/13/15 07:41 (7:41 a.m.) "Resident arrived at 11.50pm on a stretcher accompanied by 2 personal and daughter. dressing in place on both legs..."

3/13/15 14:59 (2:59 p.m.) "Skin/Wound Note"
"...This morning assessed resident's lacerations on bil lower extremities. Dr (Name) and daughter were in the room. Laceration on L leg lateral (close to knee):
6x 10 x 0.8 cm (centimeters) with 11 stitches
Laceration on R lower leg 8 x 8.5 x x 0.6 cm.
Increased edema to bil LE's (bilateral lower extremities) (legs/feet)
Also noted on L heel DTI (deep tissue injury) (bloody blister not open) 0.5 x 0.6 cm...She did not have this bloody blister before..."

Review of Resident #19's care plan included, but not limited to, the following:

"Focus The resident has an ADL (activities of daily living) self care performance deficit due to

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recent hospitalization and prolonged medical treatment for a chronic problem. She is receiving both PT and OT (Physical and Occupational Therapy) and showing progress. She remains non ambulatory at this time. Date Initiated: 02/23/2015."
"Goal She will improve current level of function in ADL's and begin working with parallel bars durig (sic) this review. Date Initiated: 02/23/2015...Revision on: 03/03/2015."
"Interventions...TRANSFER: She requires extensive assist of 1-2 staff using sliding board. Date Initiated: 02/23/2015...Revision on: 03/03/2015."

On 4/28/16 at 11:00 a.m. a review of the Physical Therapy (PT) notes was conducted. The PT notes contained the following:

"Physical Therapy Plan Of Care" initiated 2/5/15 included an "Initial Assessment"
"Functional Deficits...Weight bearing Status, Left LE...Current Level-50% weight bearing... Transfers, Bed/Chair...minimal assistance (1-25%)..."
"Functional Deficit Other Due to increased difficulty with static standing d/t (due to) pain, mode of transfer is sliding board. NSG (nursing) made aware."

02/27/2015 PT Therapist Progress note "Current Level of Function" included:

"...The patient is able to safely transfer from bed < > wheelchair requiring contact guard assist (contact with patient due to unsteadiness) with sliding board."

03/16/2015 PT-Therapist Progress & Updated

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F 323	Continued From page 11 Plan of Care included: "Current Level of Function" "Minimal assistance The patient is able to safely transfer from bed < > wheelchair requiring minimal assistance (1-25% assist)...squat pivot transfer." On 4/28/16 at 11:50 a.m. an interview was conducted with the Rehab Department Manager (Other-B) and Physical Therapist (Other-C). Other-C was identified as the primary PT who worked with Resident #19. The PT assessments and goals were reviewed. When asked what the transfer status was for Resident #19, Other-C read the initial assessment "mode of transfer is sliding board. NSG made aware." When asked how the nursing staff were taught what the appropriate transfer method was, Other-C stated we "Would generally pull the CNA off the floor and teach them on the unit." She stated we "Would expect nursing to use the sliding board until cleared to transfer another way." The PT squat pivot transfer from 3/6/15 was discussed. Other-C stated "As far as I remember I did not train nursing staff to pivot transfer (Resident #19)." The "Resident was very motivated and she tried really hard." Other-C stated "To the best of my knowledge, nursing should have been using the sliding board for transfers." The interview concluded at 12:10 p.m. An investigation report, regarding the leg lacerations was provided by the Administrator (Employee-C) and Director of Nursing (Employee-A) was reviewed on 4/28/16. The investigation report which was typed by Employee-A included: "CNA-C (Name) was the primary C.N.A and he called CNA-B (Name) for help, the wheel chair was moved close to the bed and had no foot rest.	F 323		

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Both C.N.A's had gait belts during the transfer of the resident." "Resident stated hands were swollen and really could not help with the transfer. During pivot and transfer, C.N.A's noticed resident's right leg was bleeding. CNA-C (Name) called for help and the charge nurse came into room. (Name) who was the charge nurse called (Name) the supervisor to the room. Prior to (Name) entering the room, the left leg was noticed to be bleeding also."
"Both (Name), CNA-B, CNA-C & (Name) agreed that the cut was new, the blood was fresh and that injury occurred during the transfer as the laceration and skin tear on assessment were indications of new onset and origin."
"Both CNA-C and CNA-B did not see any contact happen because they were focused on the upper body, they are however were confident that the injury was as a result of the pivot transfer..."

On 4/28/16 at 12:30 p.m. when asked what would be documented in regard to training nursing staff, Physical Therapist, Other-C stated, she "Would document in progress note if staff are trained in change of transfer status" and "If training wasn't documented then it wasn't done. She (Resident #19) wasn't cleared to stand pivot (with nursing staff)." Other-C stated she "Would've documented if we removed the sliding board from the room."

A telephone interview was conducted with CNA-B with the Director of Nursing present. In summary, CNA-B stated she remembered the day Resident #19 acquired the wounds on her legs. CNA-B stated she knew Resident #19 was a 2 person transfer but did not recall if a sliding board was in the room. She stated when the resident came back from the hospital (after the injuries) rehab

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taught staff to use the sliding board. CNA-B stated when they stood her up she began bleeding on one leg then the other but did not remember her leg hitting the wheelchair. When asked how the CNA's know how to transfer a resident (transfer status) CNA-B stated at the time there was a card (Kardex) on the back of the closet door (with the information) but now the information is in the computer. An attempt was made to contact the primary CNA (CNA-C); a voice message was left to call the facility with no return call received.

On 4/28/16 at approximately 1:25 p.m. when asked if the kardex was found, the Director of Nursing stated "There is no kardex in the record." The Administrator and Director of Nursing were informed of the harm level deficient practice due to the transfer. Administration was questioned why the CNA's would determine to use a stand pivot instead of a slide board. The Administrator asked where it was documented to use the slide board beside the rehab notes; the surveyor stated it was on the care plan and in an interdisciplinary note. At 2:30 p.m., the Administrator stated "(Name of Employee-A) and I investigated the incident fully. The MDS coordinator put the sliding board in the care plan." The Director of Nursing then stated I "Believe the MDS put in sliding board in error."

There were no concerns regarding transfers identified during the survey.

The faciltiy provided the following information after the survey:

" Resident #19 sustained lacerations to her

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F 323	Continued From page 14 bilateral lower legs on March 12, 2015 during a two person transfer. Following this incident it was determined that no other residents had been injured while being transferred, however others may possibly in the future. The Director of Nursing and the RN nursing supervisors re-educated the nursing staff on transferring resident with fragile skin on March 13, 2015. The Director of Nursing and Director of Rehab worked together to develop a new tool and policy to alert all staff to the rehab department ' s individualized plans for resident transfers, ambulation, weight bearing status, diet, liquids, NPO status, and/or special instruction. This newly developed tool and policy was presented and adopted by the facility during the April 24, 2015 Quality Improvement Committee Meeting. The Director of Nursing educated the nursing staff on this new tool during his monthly meeting held on May 12, 2015. The Director of Nursing continued reviewing all resident unusual occurrences and found none were related to improper resident transfers. The facility maintains that it was back in compliance by June 1, 2015. " This is a Past-Non Compliance Deficiency Complaint Deficiency.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		

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F 329	Continued From page 15 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure four Residents (Residents' #14, #7, #16 and #4) in a survey sample of 23 Residents were free from unnecessary medication. 1. For Resident #14, LPN (licensed practical nurse) A administered two Acetaminophen 500 mg (milligram) tablets instead of the physician ordered one tablet; 2. For Resident #7, blood pressure readings were not obtained prior to the administration of an	F 329	**F - 329** **1. Corrective Action** **Residents #14, #7, #16, and #4 suffered no ill effects due to this deficient practice.** **2. Other Potential Residents** **All geriatric residents have the potential to be affected by this deficient practice.** **3. New Measures/Systems Change** **The RN Clinical Coordinator and/or RN Nursing Supervisors will re-inservice the geriatric licensed nurses on the need for each drug regimen to be free of unnecessary drugs and on the six rights of medication administration.** **The nurse who made the medication error involving resident #14 will be re-inserviced the need for each drug regimen to be free of unnecessary drugs and on the six rights of medication administration as well as counseled for her error.**	

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F 329	Continued From page 16 antihypertensive medication per physician's order; 3. For Resident #16 the facility staff failed to hold amlodipine and metoprolol (blood pressure medications) as indicated in the physician ordered parameters. 4. For Resident #4 the facility staff failed to hold diltiazem (blood pressure medication) as indicated in the physician ordered parameters. The findings included: 1. For Resident #16, LPN (licensed practical nurse) A administered two Acetaminophen 500 mg (milligram) tablets instead of the physician ordered one tablet. Resident #14, a female, was initially admitted to the facility 8/22/14 and readmitted after a hospitalization 1/2/16. Her diagnoses included schizophrenia, atrial fibrillation, gastroesophageal reflux disease, muscle weakness, over active bladder, seizures, renal tubular interstitial disorder, extra pyramidal symptoms, syncope, sepsis, dementia, and hypothyroidism. Resident #14's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/27/16 was coded as a quarterly assessment. Resident #14 was coded as having no memory deficits and was able to make her own daily life decisions. She was coded as needing extensive assistance of one staff member to perform her activities of daily living. LPN A was observed, during medication pour and pass observation, administering medications to Resident #14 on 4/26/16 beginning at 4:10 p.m. LPN A had assessed Resident #14 for pain and determined Resident #14 required pain medication. After reviewing the eMAR (electronic medication administration record), LPN A popped	F 329	**4. Monitoring** **The RN Clinical Coordinator and/or Nursing Supervisor will audit 25% of the Medication Administration Records for all geriatric residents receiving blood pressure medications with MD ordered parameters to ensure the blood pressure medication was not administered outside of the ordered parameters. This audit allows for 100% of the geriatric residents receiving blood pressure medications to be audited monthly. The results of these audits will be shared with the Director of Nursing who will share the findings monthly over the next three months with the Administrator and the CQI Committee.** **The Geriatric RN Clinical Coordinator or the RN Nursing Supervisor will make random visual observations of the medication administration pass of the nurse who made the medication error to ensure the correct dosages are administered. These random visually observations will be done three times weekly over the course of three months. The results of these observations will be given to the Director of Nursing who will present them to the Administrator and the CQI Committee monthly.**	

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F 329	Continued From page 17 two Acetaminophen 500 mg, along with an Omega 3 1000 mg capsule, into a medication cup. LPN entered Resident #14's bedroom and administered the medications to Resident #14 at 4/26/16 at 4:15 p.m. Upon reconciliation of the medications administered with the physician's orders, the following order was noted: "3/15/16 Acetaminophen 500 mg by mouth every 8 hours as needed for pain maximum daily dose allowed=4 grms (grams)." The order was on the most recently signed physician's orders dated "4/1/16." Review of the clinical record revealed no physician's order for two Acetaminophen 500 mg to be administered for pain for Resident #16. RN (registered nurse) B, the unit manager, stated 4/27/16 at 10:24 a.m. she did not see any order for two Acetaminophen 500 mg to be administered to Resident #14 for pain. LPN A stated 4/27/16 at 4:28 p.m., she had realized after administering the medication that she had made an error by administering two Acetaminophen 500 mg instead of the physician's order of one. LPN A stated she was nervous and had administered the medication in error. Review of the facility's policy entitled, "Medication:Administration: General" included: "A licensed nurse, Med Tech, or medication aide, per state regulations, will administer medications to patients. Accepted standards of practice will be followed. Medications will not be borrowed from another patient." Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing	F 329	**5. Completion Date June 11, 2016.**	

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Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

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

The administrator, DON (director of nursing, and corporate consultant were informed of the failure of the staff to administer Acetaminophen 500 mg per physician's order to Resident #14, 4/27/16 at end of day conference. The administrator, DON, and corporate consultant were informed of LPN A administering twice the amount of Acetaminophen 500 mg to Resident #14.

2. For Resident #7, blood pressure readings were not obtained prior to the administration of an antihypertensive medication per physician's order.
Resident #7 was originally admitted to the facility on 6-9-15, and readmitted after a hospitalization on 3-8-16. Diagnoses included; Hypertension, renal insufficiency, hypothyroidism, dementia, seizure disorder, asthma, and vitamin D deficiency.

Resident #7's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4-5-16. The Resident was coded with a Brief interview for mental status (BIMS) score of 3

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F 329	Continued From page 19 points scored in a possible 15 points, indicating severe cognitive impairment. The Resident required limited assistance of staff for transferring, ambulation, and hygiene. The Resident was also coded as requiring extensive assistance of staff for dressing, and toileting. On 4-26-16 a review of Resident #7's clinical record was begun. The record revealed a signed physician's order stating "Amlodipine Besylate tablet 10 mg (milligram) one tablet by mouth at bedtime related to Essential hypertension - hold for SBP (systolic blood pressure) less than 110." This order was dated 3-12-16, and was to be given at 8:00 p.m. The MAR (Medication Administration Record) was reviewed since the time the order went into effect. This medication was administered, and the blood pressure was taken and documented on 3-15-16, 3-16-16, and 3-17-16, however, after 3-17-16, no blood pressures had been taken or documented for the 8:00 p.m. blood pressure medication. This reveals that the staff was unaware if the Resident's blood pressure was below 110 millimeters/Mercury, and the medication may have been unnecessary per the physician's order, up until 4-21-16 (34 days), when the blood pressures were again begun, and documented. The Vital signs record in the clinical electronic medical record, and nursing notes, and the clinical paper chart were reviewed, and bedtime blood pressures to be taken before giving the anti-hypertensive drug, were not completed nor documented in these records. On 4-27-16 at 3:00 p.m., an interview was conducted with the Director of nursing (DON) who stated "I guess we have not been taking the blood pressure at bedtime, and only in the morning".	F 329		

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F 329	Continued From page 20 Facility policy "Administering Medications" was reviewed and it stated "Medications must be administered according to the orders ..." Guidance for nursing practice for following physician's orders was included in Lippincott, and Potter-Perry, Fundamentals of Nursing, "The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients." The Administration was informed of findings on 4-27-16 at 5:30 p.m. No further information was available from the facility. Complaint Deficiency.	F 329		
	3. For Resident #16 the facility staff failed to hold amlodipine and metoprolol (blood pressure medications) as indicated in the physician ordered parameters. Resident #16, a 92 year old, was admitted to the facility on 11/26/08. Her diagnoses included hypertension, depression, and dementia. She had a pacemaker. Resident #16's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/18/16. She was coded with a Brief Interview of Mental Status score of 7 indicating severe cognitive impairment. She required extensive assistance with her activities of daily living.			

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F 329	Continued From page 21 Resident #16 had physician orders for two medications to treat her hypertension. These orders read: 1. Amlodipine 2.5 milligram, give 1 tablet by mouth one time a day hold for systolic blood pressure less than 120. Ordered 12/12/12 2. Metoprolol 25 milligram, give 1 tablet by mouth two times per day hold for systolic blood pressure less than 120. Ordered 3/28/16. Resident #16's April 2016 Medication Administration Record (MAR) was reviewed. On 4/23/16, blood pressure was documented as 118/63. On 4/27/16, blood pressure was documented as 112/76. On both of these dates, the systolic blood pressure was less than 120. The medications were administered on these dates when they should have been held. The errors were reviewed with the Administrator and Director of Nursing at the end of day meeting on 4/28/16. 4. For Resident #4 the facility staff failed to hold diltiazem (blood pressure medication) as indicated in the physician ordered parameters. Resident #4, a 98 year old, was admitted to the facility on 8/3/15. Her diagnoses included hypertension, atrial fibrillation, depression, and dementia. Resident #4's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 2/10/16. She was coded with a Brief Interview of Mental Status score of 14 indicating no cognitive impairment. She required extensive assistance with her activities of daily living.	F 329		

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F 329	Continued From page 22 Resident #4 had a physician order for Diltiazem. The order dated 8/3/15 read Diltiazem 180 milligram by mouth one time a day Hold for systolic blood pressure less than 110 and HR less than 60. Resident #4's April 2016 Medication Administration Record (MAR) was reviewed. On the Diltiazem entry line, daily blood pressures had been recorded but the daily heart rate had not been recorded. The issue was reviewed with the Director of Nursing (DON) and Administrator at the end of day meeting on 4/27/16. The following day, the DON stated that during the switch to the new computer system, the heart rate parameter had not been entered as part of the order and was dropped off. The heart rate had not been obtained prior to administration. He stated the switch to the new system took place on 3/15/16.	F 329		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, clinical record review, facility record review, and during a complaint investigation, the facility staff failed to ensure a physician ordered therapeutic diet was provided for two residents (Resident #7 and # 20) of 23 residents in the survey sample.	F 367	**F – 367** **1. Corrective Action** **Resident's #7and #20 suffered no ill effects from this deficient practice.** **2. Other Potential Residents** **All geriatric residents who are ordered to receive a therapeutic diet have the potential to be affected by this deficient practice.**	

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F 367	Continued From page 23 1. For Resident #7, the Resident had a physician order for a "Dysphagia advanced/mechanical Soft Foods diet." Also one staff member was required to assist while eating for safety. The Resident was observed eating a regular diet, with no assistance. 2. For Resident #20, The Resident was discharged from the hospital on a pureed dysphagia diet, with nectar thick liquids secondary to a stroke and aspiration pneumonia. Upon admission to the facility the Resident received a regular diet. The findings included: 1. Resident #7 was originally admitted to the facility on 6-9-15, and readmitted after a hospitalization on 3-8-16. Diagnoses included; Hypertension, renal insufficiency, hypothyroidism, dementia, seizure disorder, asthma, and vitamin D deficiency. Resident #7's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4-5-16. The Resident was coded with a Brief interview for mental status (BIMS) score of 3 points scored in a possible 15 points, indicating severe cognitive impairment. The Resident required limited assistance of staff for transferring, ambulation, and hygiene. The Resident was also coded as requiring extensive assistance of staff for dressing, and toileting. Resident #7 was coded on the quarterly assessment dated 4-5-16 as requiring Extensive assistance of one staff member for eating, and on	F 367	**3. New Measures/Systems Change** **The RN Clinical Coordinator and/or the RN Nursing Supervisors will re-inservice the geriatric licensed nurses on the importance of ensuring diet orders coming from the hospital are carried over to the facility and the of the importance of communicating all diet orders to the dietary department.** **4. Monitoring** **The RN Clinical Coordinator and/or the RN Nursing Supervisor will audit 100% of new admissions to ensure the diet orders coming from the hospital are carried over to the facility over the course of three months. The results of these audits will be communicated to the Director of Nursing who will report the findings to the Administrator and the CQI Committee monthly.** **The Director of Dietary Services will compare 100% of the diet orders with what the kitchen staff have as ordered every other week over the course of three months. The Director of Dietary will report his findings monthly to the Administrator the CQI Committee over the course of three months.** **5. Completion Date** **June 11, 2016.**	

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a mechanically altered diet. On the previous Significant Change assessment dated 1-4-16, the Resident was coded as requiring Extensive assistance of one staff member for eating, and no mechanically altered diet.

Resident #7's breakfast meal was observed on 4-28-16 at 9:00 a.m. The meal tray ticket read "Regular/Liberalized Breakfast Thursday 4-28-16". All foods on the tray were regular diet. No Mechanical soft foods were on the tray, which included whole toast. Resident #7 stated that she was extremely happy that he was allowed to eat foods she liked. No staff were in the room, and the Resident was eating independently, and very quickly, taking large bites, and seemingly chewing little before swallowing, while continuing to talk. The Resident coughed while talking, and the surveyor left the room. The surveyor waited in the hallway outside of the Resident's door for staff to return to the room, and CNA A entered to remove the tray. CNA A was then interviewed, and asked if the Resident needed help while eating. CNA A replied "No", and went on to say that the Resident fed herself, and that the CNA needed only to open items like the milk for the Resident, and then the Resident could eat herself. CNA A was asked if this Resident had a special diet, and she replied "No." That the Resident ate a regular diet. The Resident consumed 100% of the meal, and continued coughing intermittently when the tray was removed by CNA A.

Resident #7's clinical record was reviewed. The Director of Nursing (DON) was asked for a copy of the most recent Speech Therapy Evaluation for Resident #7. The DON delivered a Speech Therapy Initial Evaluation, dated 3-10-16. This

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was the most recent Speech Therapy evaluation in the clinical record. Under the heading "Assessment Summary" the Speech Therapist (ST) documented her findings, which read; "Swallowing impaired" and under the heading of "Recommendations" the ST documented recommendations of "Dysphagia Advanced/Mech (mechanical) Soft Foods", and "small sips and bites when eating." The physician had signed the evaluation on 3-20-16, certifying the need for these recommendations, and ordering them to be instituted as medically necessary under the plan of treatment, as was documented on the physician signature line. This order was never transcribed and sent to dining services.

On 4-27-16 the Dining Services Manager was asked to provide the diet information for Resident #7. Staff provided a copy of the 4-27-16 meal ticket. The meal tray ticket read "Regular/Liberalized." for all meals.

On 4-27-16 the Director of Nursing (DON) was asked how the nursing staff were supposed to communicate diet orders to the kitchen. He stated that they should call and tell dietary about the order change. In addition, the nurses were also supposed to fill out the form called a "Diet Order change" and take it down to the kitchen. When asked when the order should be communicated to dietary, the DON stated "as soon as possible."

Review of the nursing notes for Resident #7 revealed that on 4-2-16 the Resident was in the dining room eating and began to complain of not being able to breath, the Resident was eating pineapple chunks, and they were removed from the Resident. The note goes on to say that an

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order was received that the Resident must be monitored by staff when eating, and that a speech evaluation would be completed on 4-4-16. On 4-11-16 a social work note regarding a care plan meeting with the Resident's daughter revealed that the Resident had choked on a piece of fruit the previous weekend. Included in the note was a statement from the Speech Therapist that the Resident had food stuck in her chest, not in her throat. The Resident's daughter stated that the Resident would do this at home as well, and requested that meats be cut up. The Speech Therapist stated in the note that an Endoscopy or a Barium Swallow study was possible. After the 4-11-16 care planning note nothing further developed. According to the DON, no endoscopy or Barium Swallow was ordered, or followed up on.

Review of the previous Nutrition Care plan dated 9-11-15, and revised on 3-6-16 stated as interventions "monitor presence or absence of edema, monitor weight monthly, record and monitor meal intake daily."

The newest care plan dated 3-10-16 had no nutrition care plan instituted, and stated under the Activities of Daily Living care plan "Resident requires 1 staff member assistance with eating." None of the previous interventions were current on this plan.

Review of the current recapitulated Physician's orders revealed an order on 3-30-16 Regular/Liberalized Diet. The Resident never received the Mechanically altered diet.

The Administrator, Director of Nursing and Corporate Nurse were notified of the diet order

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F 367	Continued From page 27 never being instituted, and staff not monitoring the Resident while she ate, at the end of day meeting on 4-27-16. No further information was available to be provided according to the Administrator. 2. For Resident #20, The Resident was discharged from the hospital on a pureed dysphagia diet, with nectar thick liquids secondary to a stroke and aspiration pneumonia. Upon admission to the facility the Resident received a regular diet. Resident #20, was admitted to the facility on 6-9-15, and discharged on 7-28-15, equaling a 49 day stay. Diagnoses included; Advanced dementia, dysphagia, stroke, aspiration pneumonia, depression, Alzheimer's disease, and convulsions. Resident #20's most recent Minimum Data Set assessment was an Admission assessment with an assessment reference date of 6-16-15. Resident #20 was coded with a "severely impaired" cognitive status, and required extensive to total assistance on one to two staff members with activities of daily living. Resident #20 was a closed record review, and so no observations were possible. Resident #20's clinical record was reviewed. The Speech Therapy Initial Evaluation and plan of care, dated 6-10-15, indicated the Resident required a pureed diet with nectar thickened liquids. This was in agreement with hospital	F 367		

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discharge instructions from the Speech Therapist there who stated this diet as well. The physician had signed the facility evaluation on 6-23-15, certifying the need for these recommendations, and ordering them to be instituted as medically necessary under the plan of treatment, as was documented on the physician signature line. This order was never transcribed and sent to dining services.

On 4-27-16 the Dining Services Manager was asked to provide the diet information for Resident #20. Staff was unable to provide a copy of the Resident's meal tickets.

On 4-27-16 the Director of Nursing (DON) was asked how the nursing staff were supposed to communicate diet orders to the kitchen. He stated that they should call and tell dietary about the order change. In addition, the nurses were also supposed to fill out the form called a "Diet Order change" and take it down to the kitchen. When asked when the order should be communicated to dietary, the DON stated "as soon as possible."

Review of the nursing notes for Resident #20 revealed that on 6-9-15 in the initial nursing note, it was documented that the Resident had been receiving a pureed diet with nectar thickened liquids. On 7-8-15 (one month later) a nursing note for the Resident's care plan meeting revealed that Speech Therapy was going to begin soft food trials, and that the kitchen manager discussed and explained a pureed diet and nectar thick liquids with the Legal Guardian and the wife of the Resident. The note goes on to say that the director of nursing was present at this meeting and nursing staff discussed the Depakote

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medication that the Resident had been receiving, and since it could not be crushed, it would have to be changed to a liquid, indicating the Resident had been receiving whole medications and a regular diet.

Review of the recapitulated Physician's orders (signed 7-1-15) revealed an order on 6-9-15 for a "Regular Diet, Regular texture/Nectar consistency (liquids) Diet." The Resident never received the Pureed, diet, that was ordered by Speech therapy, and the physician on 6-10-15, as the order was never transcribed and communicated to the dietary department. On 7-8-15 the doctor ordered high calorie supplements three times per day, as the Resident was losing weight, and this was undesirable. The physician seemed unaware of the fact that the Resident had not received the pureed diet, as on 7-17-15 the physician ordered to discontinue the pureed diet and begin the Dysphagia Advanced diet (Mechanical soft).

A physician's progress note dated 7-20-15 described that the Resident was receiving "Dysphagia advanced diet (mechanical soft/chopped) with nectar thick liquids", however, the orders for Regular diet still appeared on the July physician's orders sheet.

Review of the Medication and Treatment Administration Records (MAR/TAR), revealed the area for documenting the Diet of a Resident was left blank on both of the June, and July documents.

Resident #20 was receiving a Pureed diet when he left the hospital 6-9-15, due to a stroke, and aspiration pneumonia. The Resident was

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F 367	Continued From page 30 changed to a Regular diet on admission to the facility on 6-9-15, against physician's orders, and then down graded to a Mechanical chopped diet on 7-17-15. A telephone interview was conducted with the Legal guardian, and the Complainant on 4-26-16, separately, and beginning at 3:40 p.m. According to both, the Resident never received the pureed diet. The Resident's "Patient at risk for weight loss" dysphagia care plan dated 6-19-15, and revised on 6-23-15, had the following interventions instituted; "Diet as ordered, Hydration list, Monitor weights, labs, skin, intake as needed." No diet was specified or revised in the care plan to give guidance to nursing as to the correct diet. The Administrator, Director of Nursing and Corporate Nurse were notified of the diet order never being instituted, at the end of day meeting on 4-27-16. No further information was available to be provided according to the Administrator.	F 367		
F 425 SS=D	Complaint Deficiency. 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425		

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F 425	Continued From page 31 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure an accurate accounting was maintained for medication for one Resident (Resident #14) in a survey sample of 23 Residents. For Resident #14, the staff could not account for three Acetaminophen 500 mg tablets. The findings included: Resident #14, a female, was initially admitted to the facility 8/22/14 and readmitted after a hospitalization 1/2/16. Her diagnoses included schizophrenia, atrial fibrillation, gastroesophageal reflux disease, muscle weakness, over active bladder, seizures, renal tubular interstitial disorder, extra pyramidal symptoms, syncope, sepsis, dementia, and hypothyroidism. Resident #14's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/27/16 was coded as a quarterly assessment.	F 425	**F – 425** **1. Corrective Action** **Resident #14 suffered no ill effects from this deficient practice.** **2. Other Potential Residents** **All geriatric residents have the potential to be affected by this deficient practice.** **3. New Measures/Systems Change** **The RN Clinical Coordinators and/or Nursing Supervisors will re-educated the geriatric licensed nursing staff on the six rights of medication administration.** **4. Monitoring** **The facility's pharmacy, Omnicare, will audit 100% of the facility Medication Administration Records on geriatrics to ensure medications administered are accurately accounted for. This audit will occur over the course of 90 days and the results of the audit will be presented to the Director of Nursing and the Administrator who will present the findings to the CQI Committee.** **5. Completion Date** **June 11, 2016.**	

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Resident #14 was coded as having no memory deficits and was able to make her own daily life decisions. She was coded as needing extensive assistance of one staff member to perform her activities of daily living.

Licensed Practical Nurse (LPN) A was observed, during medication pour and pass observation, administering medications to Resident #14 on 4/26/16 beginning at 4:10 p.m. LPN A had assessed Resident #14 for pain and determined Resident #14 required pain medication. After reviewing the eMAR (electronic medication administration record), LPN A popped two Acetaminophen 500 mg, along with an Omega 3 1000 mg capsule, into a medication cup. LPN entered Resident #14's bedroom and administered the medications to Resident #14 at 4/26/16 at 4:15 p.m.

Upon reconciliation of the medications administered with the physician's orders, the following order was noted:

"3/15/16 Acetaminophen 500 mg by mouth every 8 hours as needed for pain maximum daily dose allowed=4 grms (grams)." The order was on the most recently signed physician's orders dated 4/1/16."

On 4/27/16 the pill card for Acetaminophen was observed and five tablets had been removed from the card. On the pill card was documentation the card had been sent by the pharmacy to the facility on 4/21/16. When the eMAR was reviewed, only one dose of Acetaminophen had been administered to Resident #14 after 4/21/16, and that was the dose observed during medication pour and pass on 4/26/16. Two tablets had been administered in error by LPN A during that observation.

Registered Nurse (RN) A reviewed the medication card and eMAR for Resident #14 and

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F 425	Continued From page 33 stated she would have to investigate the issue, 4/27/16 at 10:24 a.m. The DON (director of nursing) stated he would investigate where the three missing tablets of Acetaminophen 500 mg, 4/27/16 at end of day conference. The DON stated the staff were not to borrow medications from one Resident for another Resident. As of the end of day conference 4/28/16, no further information was provided regarding missing Acetaminophen 500 mg tablets. The DON stated he was unable to determine what happened to the three tablets of Acetaminophen. The administrator, DON, and corporate consultant were informed of the failure of the staff to ensure Acetaminophen was accounted for for Resident #14, 4/28/16 at 1:15 p.m.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		

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F 431	Continued From page 34 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, the facility failed to ensure the medication keys were not inserted in the unlocked refrigerator pad lock (the refrigerator was behind a locked door in the nursing station on 1 of 3 nursing units. The medication keys on the pediatric unit, which opened the medication refrigerator, the narcotic box and the pixis (back up medications), were observed inserted in the unlocked refrigerator pad lock. No facility staff were within sight of the keys. The findings included: On 4/27/16 at 9:10 a.m., the medication refrigerator on the pediatric unit was observed to be unlocked with the keys inserted into the pad lock. The refrigerator was in the nursing station behind a locked door.	F 431	**F – 431** **1. Corrective Action** **No pediatric residents suffered ill effects from this deficient practice.** **2. Other Potential Residents** **All pediatric residents have the potential to be affected by this deficient practice.** **3. New Measures/Systems Change** **All pediatric licensed nurses will be re-educated on the importance of keeping the medication keys in their possession at all times and on the importance of keeping the medication carts and refrigerators locked at all times when they are not in direct contact with the medication cart and refrigerator. This re-education will be done by the RN Pediatric Clinical Coordinator and/or the RN Nursing Supervisors.**	

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F 431	Continued From page 35 The contents of the refrigerator were reviewed in the presence of a second surveyor. Approximately 30 bottles of liquid medication were stored in the refrigerator. There were two locked boxes affixed to the refrigerator door. They were locked. No nurses or any facility staff were at the nursing station or within sight of the nursing station at this time. On 4/27/16 at 9:25 a.m., Registered Nurse A (RN A) entered the nursing station. She asked the surveyors "Do you have the medication keys?" She was informed that the surveyors did not have the medication keys. She was also informed that the surveyors observed the medication keys in the pad lock on the refrigerator. RN A was asked if it was ok that the refrigerator was left unlocked with the keys inserted in the pad lock. She stated no. When asked who should be in possession of the keys, RN A stated the nursing staff should be in possession of the keys. RN A was asked which items the keys unlocked. RN A stated that the keys unlocked the refrigerator, the double locked narcotic boxes in the refrigerator and the pixis (back up medications). RN A was asked where the keys are supposed to be kept. She stated that there are three medication carts, and the keys are kept in the top drawer of the middle cart. The facility policy titled "Medication Administration General" included the section titled "Practice Standards." This section read "1. Maintain security of cart and keys at all times."	F 431	**4. Monitoring** **The visually observations to ensure the medication carts and refrigerators are locked when a licensed staff person is not present will be done. These observations will be done daily on rounds by the RN Pediatric Clinical Coordinator or the Director of the Pediatric unit a minimum of five times per week and by the RN nursing supervisors on the evening, night and weekend shifts. The results of these audits will be presented to the Director of the Pediatric unit and she will present the findings monthly to the Administrator and the CQI Committee monthly over the course of three months.** **5. Completion Date** **June 11, 2016.**	

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F 431	Continued From page 36 At the end of day meeting on 4/27/16, the Administrator and Director of Nursing were notified that the medication keys were left unattended in the unlocked medication refrigerator pad lock.	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed for one resident (Resident #11) of 23 residents in the survey sample to maintain an accurate record. For Resident #11, the facility staff failed to accurately document the times a wrist brace was applied and removed. The findings included: Resident #11 was admitted to the facility on 8/21/14 with the diagnoses of, but not limited to,	F 514	**F – 514** **1. Corrective Action** **Resident #11suffered no ill effects from this deficient practice.** **2. Other Potential Residents** **All geriatric residents with orders for extremity braces/splints have the potential to be affected by this deficient practice.** **3. New Measures/Systems Change** **The RN Clinical Coordinator and the RN Nursing Supervisors will re-inservice the geriatric nursing staff on importance of accurately documenting the times a brace/splint is applied and removed.** **The application and removal of braces/splints will been added to the Treatment Administration Record to ensure a licensed nurse is checking the times for application and removal of braces/splints.**	

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F 514	Continued From page 37 Parkinson's disease, CVA (cerebrovascular accident-stroke) and osteoporosis. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/20/16. The MDS coded Resident #11 with intact cognition; extensive assistance required from staff for all activities of daily living; and had range of motion limitation on the upper body, one side. On 4/26/16 at 8:20 a.m. Resident #11 was observed lying in bed. She was alert and answered questions with one word answers. Resident #11's clinical record was reviewed on 4/27/16. The review revealed a physician's order which read: "RIGHT WRIST BRACE TO BE WORN AT DAY TIME 8am AND OFF AT 12 PM FOR BADL (basic activities of daily living) TASKS." The original order was written 1/30/15. Review of the February 2016 Medication (MAR) and Treatment (TAR) Administration Records revealed the wrist brace was documented as being placed on and taken off at the ordered times. The 2016 March and April MAR and TAR did not contain the order or documented use of the brace. Further review of the electronic clinical record revealed a "Visual/Bedside Kardex Report" which included directives on how Resident #11 was to ambulate, eat, dress/groom/bath, what skin care was to be performed, restorative nursing directives and other devices. The "Other Devices" section read: "Right Wrist Brace to be worn during the day time. On at 8am & off at 2pm. _8am_on and 12 pm off times."	F 514	**4. Monitoring** **The RN Clinical Coordinator and RN Nursing Supervisors will audit 50% of the geriatric residents who have orders for brace/splint application to ensure that the correct time has been recorded for application and removal. This audit will be done weekly thus will result in 100% of the geriatric residents with orders for brace/splint application and removal to be audited every two weeks. The results of these audits will be shared with the Director of Nursing who will share the findings monthly over three months with the Administrator and the CQI Committee.** **5. Completion Date** **June 11, 2016.** RECEIVED MAY 13 2016 VDH/OLC	

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F 514	Continued From page 38 On 4/27/16 at 10:55 a.m. an interview was conducted with the Assistant Director of Nursing-Registered Nurse B (RN-B). When asked why the brace was on the February TAR and not after, RN-B explained the facility switched from one computer system to another in March 2016 and "In the process of moving the orders to ancillary it doesn't show on MAR or TAR." She stated "You'll see the break in (the) system." When asked who was supposed to put on and take off the brace, RN-B stated "Restorative does it." The Restorative nursing documentation was reviewed and revealed that the times of applying and removing the brace varied and were not according to the orders. 4/14/16 was documented as on at 1:04 p.m. and off at 1:04 p.m., 4/15/16-on at 11:39 a.m. and off at 2:25 p.m., 4/16/16-on at 11:25 a.m. and off at 2:12 p.m., etc. Per RN-B, the documentation "Depends on the time they document are the times that are there." The concern that there is no documentation of the applying the brace at the ordered times was discussed. There was no decline in range of motion or contracture formation identified. After the interview with RN-B the order for the wrist brace application and removal was observed on the TAR. On 4/27/16 at 11:30 a.m., Resident #11 was observed in her wheelchair being rolled by a staff member with the right wrist brace in place. On 4/27/16 at 3:55 p.m., the Administrator and Director of Nursing were informed of the lack of the wrist brace documentation on the March and April 2016 TAR, the inconsistent/varied times documented on the Restorative charting and the Kardex listing 2 different wrist brace removal	F 514		

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F 514	Continued From page 39 times. The Director of Nursing (Other-A) stated on 4/28/16 at 8:30 a.m. that the "Documentation showed that it was put on and taken off, not the times it was done." It was determined it was a documentation error. The facility staff did not present any further information regarding the findings.	F 514		