KINGS DAUGHTERS
COMMUNITY HEALTH & REHAB
a Consulate Health Care Center

March 23, 2016

Paul Wade, LTC Supervisor
Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485

Dear Mr. Wade:

Please accept the attached plan of correction for the deficiencies received during the unannounced Medicare/Medicaid standard survey ending 3/9/16, at Kings Daughters Community Health & Rehab.

If you have any questions please contact me at (540) 886-6233.

Sincerely,

Brian Reinmann, LNHA
Executive Director

Enclosures

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State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495344	A. BUILDING _____ B. WING _____	03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGS DAUGHTERS COMMUNITY HEALTH & REHA	1410 NORTH AUGUSTA STREET STAUNTON, VA 24401

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection survey was conducted 03/8/16 through 03/9/16. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey. The census in this 117 bed facility was 107 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents 1 through 19) and 3 closed record reviews (Residents 20 through 22).	F 000	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: POLICIES AND PROCEDURES 12VAC-371-140 (A) Based on staff interview, employee record review, and facility document review, the facility staff failed to implement policies and procedures for abuse prevention. The facility staff failed to implement policies and procedures for abuse screening by failing to complete criminal background checks prior to employment, for four of 25 employees (records). Findings include: On 03/09/16 at 1:30 p.m., the BOC (business office coordinator) was interviewed with the survey team regarding the employee criminal background review.	F 001	**F 001** 1. Criminal background checks are completed. 2. All employees have the potential to be affected. A review of employee files has been completed for criminal background checks. 3. Business Office Coordinator has been in-serviced by the Executive Director on policy and procedure for proper screening of new employees for a criminal background check. The Executive Director will review potential employee files for completion of criminal background checks prior to start date. Audit will be conducted for three (3) months.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian Reinmann	Executive Director	3-23-16

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F 001	Continued From Page 1 The BOC was asked to provide verification of criminal background checks through the Virginia State Police for, four of 25 employee records reviewed (employee # 4, 15, 16, and 17). The BOC voiced that she would have to look for information regarding these employees and voiced that she knew she had completed them, but did not have that information in their employee record. A policy was requested on screening potential employees prior to employment, for possible abuse/neglect at this time. The facility's policy on screening employees (Background Checks) was presented and reviewed. The policy documented: "...conduct background checks to include criminal background checks...Please refer to your state specific requirements...Each facility will maintain a copy of and comply with, their respective state law requiring criminal background checks...criminal background inquiries shall be maintained in a secure file..keep secured files, titled, "Background Checks"...State and/or Federal criminal services, defined by individual state guidelines...Under no circumstances is a job candidate to begin work until the candidate's background check is completed and a positive report is received, unless state requirements allows a mechanism to begin employment prior to receipt of background check (Please refer to your state specific requirements)..." The administrator, DON (director of nursing) and nurse consultant were made aware in a meeting with the survey team on 03/09/16 at approximately 3:00 p.m.	F 001	4. Results of this audit will be reviewed monthly at the Quality Assurance Committee for review and discussion. Once the committee determines the problem no longer exists, audits will be conducted on a random basis. 5. April 11, 2016	

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F 001	Continued From Page 2 The BOC did not provide any additional or further information and/or documentation regarding criminal background checks for the above listed employees. No further information or documentation was provided prior to the exit conference on 03/09/16 at 4:00 p.m. Cross Reference to F-Tag 278 12 VAC 5-371-250 (A) Cross Reference to F-Tag 280 12 VAC 5-371-210 (A)(3) Cross Reference to F-Tag 281 12 VAC 5-371-200 (B)(1)(ii) Cross Reference to F-Tag 309 12 VAC 5-371-220 (A)/(B) Cross Reference to F-Tag 323 12 VAC 5-371-220 (A) Cross Reference to F-Tag 431 12 VAC 5-371- 300 (A)/(B) Cross Reference to F-Tag 502 12 VAC 5-371-310 (A) Cross Reference to F-Tag 504 12 VAC 5-371-310 (A) Cross Reference to F-Tag 514 12 VAC 5-371-360 (E)	F 001	12 VAC 5-371-250 (A), Refer to F-278, completion date 4/11/16. 12 VAC 5-371-210 (A)(3), Refer to F-280, completion date 4/11/16. 12 VAC 5-371-200 (B)(1)(ii), Refer to F-281, completion date 4/11/16. 12 VAC 5-371-220 (A)/(B), Refer to F-309, completion date 4/11/16. 12 VAC 5-371-220 (A), Refer to F-323, completion date 4/11/16. 12 VAC 5-371-300 (A)/(B), Refer to F-431, completion date 4/11/16. 12 VAC 5-371-310 (A), Refer to F-502, completion date 4/11/16. 12 VAC 5-371-310 (A), Refer to F-504, completion date 4/11/16. 12 VAC 5-371-360 (E), Refer to F-514, completion date 4/11/16.	

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/8/16 through 03/9/16. 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 117 certified bed facility was 107 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents 1 through 19) and 3 closed record reviews (Residents 20 through 22).	F 000	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278	**F278** 1. Resident #8 has received a modification to the admission assessment ARD 8/14/15 regarding section O "special treatments, procedures, and programs." Resident #9 has received a modification to the significant change ARD 11/7/15 regarding section O "special treatments, procedures, and programs." 2. Residents currently residing in the facility have the potential to be	

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Brian Reinmann RE | Executive Director | 3-23-16

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 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) for two of 22 residents, Resident # 8 and Resident # 9. 1. The facility failed to ensure Resident # 8's influenza and pneumonia vaccination status were coded correctly on two MDS assessments. 2. The facility failed to ensure Resident # 9's pneumonia vaccination status was coded correctly on a significant change MDS, dated 11/07/15. Findings include: 1. The facility failed to ensure Resident # 8's influenza and pneumonia vaccination status were coded correctly on two MDS assessments. Resident # 8 was originally admitted to the facility on 12/26/14, with the most current readmission on 08/07/15. Diagnoses for Resident # 8 included, but were not limited to: obesity, pulmonary fibrosis, hypoxia, and pneumonia. The most current full MDS was an admission assessment dated 08/14/15, which assessed the	F 278	affected. Minimum Data Set review will be conducted by the Minimum Data Set Coordinator/designee of MDSs completed within the last ninety (90) days. This review will include that the MDS is coded accurately for section O "special treatments, procedures, and programs." 3. In-servicing has been provided to the Minimum Data Set Coordinators/designee by the regional case mix coordinator (RCMC)/designee on accurate coding of the MDS for section O according to the RAI manual. Random weekly review of the MDS by the MDSC/designee for five (5) residents per week for three (3) months will be completed to ensure that the MDS is accurately coded for section O "special treatments, procedures, and programs." 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. April 11, 2016	

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F 278	Continued From page 2 resident with a cognitive score of 11, indicating the resident had moderate impairment in daily decision making skills. This MDS also coded that the resident had not received the influenza or pneumonia vaccine and additionally documented that neither had been offered to the resident by the facility. The most recent quarterly MDS assessment dated 02/14/16 was reviewed for comparison. This MDS assessed the resident as having a cognitive score of 6, indicating severe impairment in daily decision making skills and again coded the resident as not having the influenza or pneumonia vaccine and neither were offered to the resident by the facility. During clinical record review on 03/08/16, Resident # 8's diagnoses included, pneumonia. The resident's immunization record was reviewed for the flu and pneumonia vaccine and all areas were blank. On 03/09/16 at approximately 8:30 a.m., MDSC (minimum data set coordinator) # 1 was asked for assistance as to why the vaccine was not offered to the resident. MDSC # 1 voiced that she got her information from the immunization record in the chart and since it was blank and the consent wasn't filled out, she could not tell whether he (the resident) wanted it or not. The MDSC # 1 then voiced that she had notified the ADON (assistant director of nursing) on 02/24/16 and as far as the previous MDS, she did not complete that one. The MDSC # 1 was asked what the process is if there is no information in the immunization record. The MDSC # 1 voiced the process is to notify nursing that the form was blank.	F 278		

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F 278	Continued From page 3 A policy was requested at that time. The administrator, DON (director of nursing) and nurse consultant were made aware in a meeting with the survey team on 03/09/16 at 10:20 a.m. The policy was presented and documented: "...Record immunizations and vaccination of influenza administration on the TB screening and immunization record and file in the medical record. File the consent in the medical record...corresponding documentation in the medical record, the MAR (medication administration record), and the immunization record and TB log..." No further information or documentation was provided prior to the exit conference on 03/09/16 at 4:00 p.m. 2. The facility failed to ensure Resident # 9's pneumonia vaccination status was coded correctly on a significant change MDS, dated 11/07/15. Resident # 9 was admitted to the facility on 03/22/10, with the most current readmission on 06/24/15. Diagnoses for Resident # 9 included, but were not limited to: glaucoma, renal insufficiency, arthritis, dementia, and chronic pain. The most current full MDS was a significant change assessment dated 11/07/15, which assessed the resident with a cognitive score of 2, indicating the resident had severe impairment in daily decision making skills. This MDS also coded that the resident had not received the	F 278		

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F 278	Continued From page 4 pneumonia vaccine and additionally documented that it had not been offered by the facility. The most recent quarterly dated 02/07/16 was reviewed for comparison. This MDS assessed the resident as having a cognitive score of 2, indicating severe impairment in daily decision making skills and coded the resident's pneumonia status being up to date in section O0300. A. of the MDS. During clinical record review on 03/08/16 Resident # 9's MDS assessments were reviewed and documented the above. On 03/08/16 at approximately 3:10 p.m., MDSC (minimum data set coordinator) # 2 was asked for assistance in clarification between the two MDS assessments for the pneumonia vaccine. MDSC # 2 voiced that the resident had actually received a pneumonia vaccine on 02/13/11 and that this was just an oversight. The administrator, DON (director of nursing) and nurse consultant were made aware in a meeting with the survey team on 03/09/16 at 10:20 a.m. No further information or documentation was provided prior to the exit conference on 03/09/16 at 4:00 p.m.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	F280 1. For Resident #16, the care plan was revised regarding wandering. 2. Residents currently residing in the facility have the potential to be affected. The DCS/designee will	

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F 280	Continued From page 5 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the CCP (comprehensive care plan) for one of 22 residents in the survey sample, Resident # 16. The facility staff failed to review and revise the CCP for Resident # 16 regarding interventions for wandering. Findings include: Resident# 16 was admitted to the facility on 01/03/11. Diagnoses for Resident # 16 included, but were not limited to: muscle weakness, depression, bradycardia, chronic pain, anxiety disorder, dementia and recurrent falls. The most current MDS, a quarterly assessment dated 02/09/16 assessed the resident as having a cognitive score of 10, indicating the resident had	F 280	review care plans for residents currently residing in the center that have experienced wandering within the last thirty (30) days to ensure that the care plan has been revised regarding wandering. 3. In servicing has been provided to the interdisciplinary team by the DCS/designee on the proper method of updating and revising the plan of care to reflect the interventions for wandering residents. Random weekly review will be conducted by the DCS/designee for five (5) residents per week for three (3) months to ensure that the care plan has been revised for wandering. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. April 11, 2016 RECEIVED MAR 24 2016 VDH/OLC	

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F 280	Continued From page 6 moderate impairment in daily decision making skills. During clinical record review on 03/09/16, the resident's most current POS (physician's order sheet) was reviewed and included an order for, but not limited to: "...wanderguard on at all times check placement every shift due to elopement risk..." A nursing note dated 12/21/15 documented that the resident was attempting to leave via the loading area, with alarm sounding. It was further documented through out the clinical record that the resident had a history of wandering, with attempts to exit the unit on several occasions. Resident # 16 was observed at approximately 3:00 p.m. on 03/08/16 at the nurses station, sitting in her w/c (wheelchair). The resident was observed with a wanderguard on her right wrist and was speaking to the unit manager. The resident voiced that she wanted to go downstairs and that the last time she went someone (staff) 'jerked her off like an animal', the resident further voiced that it made her feel awful. The unit manager was interviewed on 03/09/16 at approximately 8:50 a.m. The unit manager voiced that the resident wanders around the facility and that the resident's daughter works down stair and the resident is always trying to get on the elevator and attempting to leave. The resident's CCP (comprehensive care plan) was then reviewed and documented: "...poor safety awareness...psychoactive drug	F 280		

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F 280	Continued From page 7 use...adaptive equipment-wonder (sic) guard...maintain a clear pathway..." The CCP did not include any interventions regarding the resident's history of attempting to leave via elevator or going downstairs where the resident's daughter worked. The CCP did not address interventions or how to remove the resident from the elevator if and when that occurred. The administrator, DON (director of nursing) and the nurse consultant were made aware in a meeting with the survey team on 03/09/16 at approximately 3:00 p.m., regarding the lack of interventions in place for wandering (other than the wanderguard) for Resident # 16. No further information or documentation was presented prior to the exit conference on 03/09/16 at 4:00 p.m.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow professional standards of nursing for one of 22 residents, Resident #13. The SSI (sliding scale insulin) orders for Resident #13 contained conflicting parameters. The nurse's administering the insulin did not question	F 281	F281 1. For resident #13 there were no adverse effects to residents identified related to the medication variance. The physician was notified and sliding scale insulin (SSI) order was clarified. 2. Residents currently residing in the facility that are receiving insulin have the potential to be affected. A review of current residents receiving SSI has been conducted to ensure SSI is being administered per	

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F 281	Continued From page 8 the conflicting parameter orders. Findings were: Resident #13 was most recently readmitted to the facility on 04/18/2015. Her diagnoses included, but were not limited to: Pelvic fracture, diabetes mellitus, dementia, CAD (coronary artery disease), PVD (peripheral vascular disease), depression and fibula fracture. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/2/2015. Resident #13 was assessed as having a cognitive summary score of "06", indicating severe impairment with her cognitive status. The clinical record was reviewed on 03/08/2016 at approximately 3:00 p.m. The POS (physician order sheet) was reviewed. Resident #13 had orders for SSI (sliding scale insulin) to be given three times per day based on blood sugar parameters. The orders were: "NOVOLOG FLEX PEN PREF [prefilled] SYR [syringe] 100 UNITS/1 ML INSULIN PEN THREE TIMES DAILY- FOR BLOOD SUGAR 150-199 2 UNITS, 200-249 3 UNITS, 250-399 4 UNITS, 300-349 5 UNITS, > [greater than] 349 6 UNITS" Parameters for blood sugars from 300 to 399 were conflicted regarding the number of units of SSI Resident #13 was to receive. MARs (medication administration records) were reviewed from November 2015 through the 03/08/2016. The December MAR had been changed to reflect a SSI range of: "150-199 2 UNITS, 200-249 3 UNITS, 250-299 4 UNITS,	F 281	physician's order. Additionally, medication observations will be conducted by the DCS/designee for currently employed licensed nurses. 3. In-servicing will be provided to the licensed nurses by the DCS/designee regarding the six (6) rights of medication administration including administering medications following physician orders and to ensure that all orders are being written, transcribed, and followed correctly. Random weekly observations of medication administration will be conducted by the DCS/designee for three (3) licensed nurses per week for three (3) months to ensure that the six (6) rights of medication administration are followed including administering medications following physician orders and to ensure that all orders are being written, transcribed, and followed correctly. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. April 11, 2016	

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	495344	A. BUILDING _____ B. WING _____	03/09/2016

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F 281	Continued From page 9 300-349 5 UNITS, >349 6 UNITS" All other MARS reviewed contained the conflicting parameters. In November 2015 Resident #13's blood sugars were recorded in the range of 300 -399 a total of 49 times, January 2016 a total of 27 times, February 2016 24 times and March 2016 three times. SSI insulin dosages varied between the parameters listed on the POS. The ADON (assistant director of nursing) was interviewed on 03/08/2016 at approximately 3:45 p.m. regarding the conflicting SSI orders. She looked back through the clinical record and stated, "I need to check on that, I think pharmacy may have made a mistake." The ADON was asked if the nurse's should have gotten clarification for the order. She stated, "Yes, that should have been corrected." On 03/08/2016 at approximately 4:00 p.m. LPN (licensed practical nurse) #2 was observed at the medication cart outside of Resident #13's room. LPN #2 was asked if she had checked Resident #13's blood sugar. She stated, "Yes, it was 294." LPN #2 was asked how much insulin she would give Resident #13 if her blood sugar reading had been 320. She looked at the MAR and stated, "I would give her 5 units. The order is for 300 -349 give 5 units." LPN #2 was asked to read the entire SSI order. She read the order on the MAR and stated, "Oh, I see what you are talking about. That should probably be 250 to 299 not 399." On 03/09/2016 at approximately 8:30 a.m. the ADON spoke with this surveyor regarding the SSI orders. She stated, "The original order had the correct scale, pharmacy transcribed it incorrectly."	F 281		

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F 281	Continued From page 10 The DON (director of nursing) and the administrator were notified of the above information on 03/09/2016 at approximately 10:30 a.m. during a morning meeting. The DON was asked if the conflicting parameters should have been questioned by the nurses administering the SSI and the nurses checking the orders. He stated "Yes." The DON was asked who's responsibility it was to ensure the orders were accurate. He stated, "It comes down to the unit manager." According to Potter and Perry, Fundamentals of Nursing, 6th Edition, Page 419 regarding physician orders: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the the orders are in error or would harm clients. Therefore all orders must be assessed, and if one is found to be erroneous or harmful, further clarification from the physician is necessary. On page 837 under Administering Medications: "The nurse does not have sole responsibility for medication administration. The prescriber and pharmacist also help ensure the right medication gets to the right client. However, the nurse administering medications is accountable for knowing which medications are prescribed, their therapeutic and nontherapeutic effects, and the medications' associated nursing implications..." Continuing on Page 852 regarding medication administration, "Check accuracy and completeness of each MAR or computer printout with prescriber's written medication order. Check client's name, medication name and dose, route of administration, time for administration and indication for medication." (1)	F 281		

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F 281	Continued From page 11 No further information was received prior to the exit conference on 03/09/2016. (1) Potter, Perry. Fundamentals of Nursing Practice, 6th Edition. Mosby. St. Louis, Missouri. 2001.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and medication pass observation, the facility staff failed follow physician's orders for one of 22 Resident's, Resident # 2 in the survey sample. 1A.) Resident #2 did not have physician ordered abduction wedge pillow when up in wheelchair. 1B.) Resident #2 did not receive the correct medication during medication pass observation. Findings include: 1A. Resident #2 was admitted to the facility on	F 309	F309 1. For resident #2, physician order was obtained to use abduction wedge PRN per resident request. A new wheelchair cushion has been ordered to improve resident's comfort and safety. For resident #2 there were no adverse effects related to the medication variance. A physician order was received to change medication to Calcium Citrate with Vitamin D. Resident #2 is currently receiving Calcium Citrate with Vitamin D 2. Residents currently residing in the facility have the potential to be affected. The following reviews will be conducted: a) a review will be completed for current residents with physician orders within the past thirty (30) days to ensure abduction	

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F 309	Continued From page 12 12/15/14 with diagnoses including, but not limited to: Hypertension, anemia, arthritis, muscle weakness, and depression. The most recent MDS (minimum data set) was a annual assessment with an ARD (assessment reference date) of 12/23/15. Resident #2 was assessed as being cognitively intact with a total cognitive score of 11 out of 15. Resident #2's clinical record was reviewed on 3/8/16. Resident #2's current physician's order set was reviewed and the following order was documented: "...2/08/16: ABDUCTION WEDGE TO BE PLACED BETWEEN KNEES WHILE IN WHEELCHAIR AND IN BED EVERY SHIFT..." On 3/9/16 at 9:05 a.m. this surveyor observed Resident #2 sitting in a wheelchair in Resident #2's room. Resident #2 was positioned with the buttocks at the front edge of the wheelchair, legs stretched out with feet on floor, a pillow behind Resident #2's back (in a diagonal like position), and without the physician ordered abduction pillow. At this time, this surveyor asked Resident #2's nurse to observe Resident #2. Resident #2's nurse (identified as license practical nurse, LPN #1) was asked about Resident #2's abduction wedge, after looking around the room, LPN #1 verbalized that she was not sure where the abduction wedge was. On 3/9/16 at 9:15 a.m. Resident #2's assigned certified nursing assistant (CNA #1) was then interviewed concerning the above finding. CNA #1 verbalized Resident #2 was gotten out of bed by the previous shift and was unaware that	F 309	wedges are in place per physician's order. b) a review will be completed for current residents with physician orders for calcium within the past thirty (30) days to ensure calcium is being administered per physician order. Additionally, medication observations will be conducted by the DCS/designee for currently employed licensed nurses. 3. In-servicing will be provided as following: a) the DCS/designee will provide in servicing to the licensed nurses regarding residents with physician orders for abduction wedge to ensure the wedge is in place per physician orders. b) the DCS/designee will provide in servicing to the licensed nurses regarding the six (6) rights of medication administration including administering medications per physician's order. Random weekly observations of medication administration will be conducted by the DCS/designee for three (3) licensed nurses per week for three (3) months to ensure that the six (6) rights of medication administration are followed including administering medications following physician orders	

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F 309	Continued From page 13 Resident #2 needed a abduction wedge. Immediately following the interview with CNA #1 , The unit manager (Registered Nurse, RN #1) and this surveyor went back into Resident #2's room. RN #1 proceeded to look in Resident #2's closet and bathroom and was unable to locate the abduction wedge. RN #1 verbalized that Resident #2 had recently been fitted with a new wheelchair and cushion and was possible that the abduction wedge had been discontinued. Resident #2's physician orders were reviewed again and did not evidence any discontinuation order of the abduction wedge. On 3/9/16 at 9:25 a.m. The therapy manager (other staff, OS #1) was interview concerning the above finding. OS #1 verbalized that abduction wedges are used for proper positioning of a resident and to help keep a Resident from sliding out of a wheelchair. OS #1 was not able to find evidence that a recommendation was made by therapy to discontinue the Resident #2's abduction wedge, but did provide documentation of evaluation for a new wheelchair to include a cushion for comfort and skin integrity. On 3/9/16 at 10:30 a.m. the above finding was brought to the attention of the administrator and director of nursing. No other information was provided regarding the above finding prior to exit conference on 3/9/16.	F 309	4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. April 11, 2016	

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F 309	Continued From page 14 B. Resident # 2 was not administered the correct formulation of calcium during the medication pass and pour observation. A medication pass and pour observation was conducted in the facility 3/9/16 with LPN (licensed practical nurse) # 1 beginning at 7:50 a.m. As LPN # 2 was preparing medications to administered to Resident # 2, this surveyor recorded the medications to be given from the pharmacy label on the medications. LPN # 2 got a bottle of medication from the medication cart drawer and stated "She gets one of these too." The bottle of medication, a "house stock" medication, was labeled as "Calcium Citrate and Vitamin D3 630/500." The medications were then administered to the resident. On 3/9/16 at 8:15 a.m. the clinical record was reviewed for reconciliation of the medications administered. The current POS (physician order summary) included an order carried forward from 9/2/15 for "Calcium Citrate 1 GM (gram): 1 by mouth every day." An order for the calcium citrate with vitamin D3 as administered to the resident was unable to be located. At 8:30 a.m. on 3/9/16, this surveyor asked LPN # 2 about the order. LPN # 2 retrieved the bottle of calcium that had been administered and stated "Oh, I don't know; this is what she's been getting." The directions on the bottle directed that 2 tablets were a serving, and the calcium citrate amount was listed as 500 IU (international units). At this time, the DON (director of nursing), who was walking up the hallway toward this surveyor and LPN # 2, came and asked if there was a problem. The discrepancy in the order and the	F 309		

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F 309	Continued From page 15 administration was shared the DON. This surveyor asked if it was known if 500 IU's were equivalent to 1 gram of the calcium. The DON stated "I don't know; we can call the pharmacy and find out." This surveyor also asked if calcium citrate, as ordered, also included vitamin D3. The DON stated he would explore the medication, and also determine the amount of calcium the resident had been receiving. After looking over the medication bottle, reviewing the order as written, and attempting to convert IU's to grams, the DON stated "I think she's been getting the wrong medication. You caught us in a med error." On 3/9/16 at 8:45 a.m. the DON came to the nurses' station where this surveyor was waiting. He had a bottle of medication in his hand and stated "This was in the stock room. This is what [Resident # 2] should have been getting." The DON then showed the bottle to this surveyor. The bottle was labeled as "Calcium Citrate 1 GM. Serving size: 4 tablets equal 1 GM." The administrator, DON, and regional director of clinical services were informed of the above findings during a meeting with facility staff 3/9/16 at 10:30 a.m. No further information was provided prior to the exit conference.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	F323 1. For Resident #16, a physician's order was received to discontinue the use of non-skid strips, due to	

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F 323	Continued From page 16 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure safety interventions were in place for one of 22 residents in the survey sample, Resident # 16. The facility staff failed to ensure physician ordered non-skid strips were in place for Resident # 16. Findings include: Resident# 16 was admitted to the facility on 01/03/11. Diagnoses for Resident # 16 included, but were not limited to: muscle weakness, depression, bradycardia, chronic pain, anxiety disorder, dementia and recurrent falls. The most current MDS, a quarterly assessment dated 02/09/16 assessed the resident as having a cognitive score of 10, indicating the resident had moderate impairment in daily decision making skills. During clinical record review on 03/09/16, the resident's most current POS (physician's order sheet) was reviewed and included an order for, but not limited to: "...Non-skid strips at right side of bed every shift..." The resident's CCP (comprehensive care plan) was then reviewed and documented: "...encourage resident to wear visual aides as	F 323	other safety measure being in place and appropriate. 2. Residents currently residing in the facility have the potential to be affected. A review will be conducted by the DCS/designee for residents that have physician orders for non skid strips to ensure the order for the use of non-skid strips is appropriate. 3. In-servicing will be provided to the nursing staff by the DCS/designee on the proper use of non-skid strips, and on following physician's orders related to the use of non-skid strips. Additionally, the DCS/designee will review five (5) residents weekly for three (3) months to ensure that physician orders for non-skid strips are being followed. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. April 11, 2016	

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F 323	Continued From page 17 appropriate...ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair)...non skid strips to floor bedside..." At approximately 2:00 p.m. on 03/09/16, Resident # 16's room was observed. No non-skid strips were observed on the either side of the bed on the floor. At 2:05 p.m., the MDSC (minimum data set coordinator) # 2 was asked to look at Resident # 16's room/floor. MDSC # 2 and this surveyor went to the resident's room an viewed the floor. MDSC # 2 voiced that there were no non-skid strips on either side of Resident # 16's bed on the floor, as ordered by the physician. The administrator, DON (director of nursing) and the nurse consultant were made aware of a meeting with the survey team on 03/09/16 at approximately 3:00 p.m. No further information or documentation was presented prior to the exit conference on 03/09/16 at 4:00 p.m.	F 323		
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.	F 431	F431 1. The identified bottle of Ativan in the eclipse medication room was discarded by the DCS. 2. Residents currently residing in the center have the potential to be affected. A review of liquid controlled substances was	

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F 431	Continued From page 18 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to ensure expired medications were not available for administration on one of three units: the Eclipse unit. The Eclipse unit medication refrigerator contained two bottles of expired Lorazepam (an anti-anxiety medication). On 3/9/16 at 9:00 a.m. an inspection of the medication room on the Eclipse unit was conducted with RN (registered nurse) # 2. During	F 431	conducted by the DCS to ensure that opened bottles were not expired, according to the manufacturer/supplier, and pharmacy guidelines. 3. In-servicing has been provided by the DCS/Designee to Licensed Nurses regarding the shelf life of Ativan once it has been opened. Random weekly audits will be conducted by the DCS/designee for three (3) months ensure that no expired liquid Ativan is available for administration. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. April 11, 2016	

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F 431	Continued From page 19 inspection of the medications stored in the unit medication refrigerator, it was noted to include two boxes of Lorazepam 2 mg/ml with bottles of the medication in each box. On the top of each box was a handwritten date. One date recorded "10/20/15" and the other date was recorded "9/18/15." RN # 2 was asked what the dates meant, and she stated that indicated the date each bottle had been opened. RN # 2 was then asked if she knew what the expiration date of the medication would be, she stated she did not, but assumed it would be the expiration date on the box. RN # 2 was asked if she knew what the recommended expiration date was according to the package insert, which was still in the box, and she stated she did not. RN # 2 was then asked if there was a policy for the storage and labeling of medications kept in the refrigerator, and she referred me to the DON (director of nursing). As this surveyor was leaving the unit, the regional director of clinical services (DCS) was walking toward the unit. The DCS was asked for a copy of the facility policy for storage and labeling of medications. On 3/9/16 at 9:15 am. the DCS presented the facility policy to this surveyor. The policy, "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" was then reviewed. The policy documented "4. Facility should ensure that medications and biologicals: 4.2 Have not been retained longer than recommended by the manufacturer or supplier guidelines; or ..... 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the	F 431		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495344	A. BUILDING _____ B. WING _____	03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGS DAUGHTERS COMMUNITY HEALTH & REHAB	1410 NORTH AUGUSTA STREET STAUNTON, VA 24401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 20 medication has a shortened expiration date once opened." The package insert for Lorazepam instructed "Discard open bottle after 90 days." The administrator, DON, and regional director of clinical services were informed of the above findings during a meeting with facility staff 3/9/16 at 10:30 a.m. No further information was provided prior to the exit conference.	F 431		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to ensure a physician ordered laboratory test was completed for one of 22 residents, Resident # 8. The facility failed to ensure a physician ordered Hgb (hemoglobin) A1C was completed for Resident # 8. Findings include: Resident # 8 was originally admitted to the facility on 12/26/14, with the most current readmission on 08/07/15. Diagnoses for Resident # 8 included, but were not limited to: obesity, pulmonary fibrosis, hypoxia, and DM (diabetes	F 502	F502 1. For Resident #8, the physician and responsible party was notified of the HGBA1C not drawn in August 2015. There were no adverse affects identified. 2. Residents currently residing in the center with lab orders have the potential to be affected. A review has been conducted by the DCS/designee for residents residing in the center with lab orders in the past thirty (30) days to ensure that labs have been obtained per physician orders. 3. In-servicing has been provided to licensed nurses by the DCS/designee regarding obtaining labs per the physician's order.	

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F 502	Continued From page 21 mellitus). The most recent quarterly MDS (minimum data set) dated 02/14/16 was reviewed. This MDS assessed the resident as having a cognitive score of 6, indicating severe impairment in daily decision making skills. During clinical record review on 03/09/16, Resident # 8's current POS (physician's orders sheet) was reviewed and included an order for, but not limited to: 'CMP (comprehensive metabolic panel), HgbA1C, and Lipid panel' to be completed annually in November and every 3 months. Resident # 8's labs were reviewed for August 2015, November 2015 and February 2016. A HgbA1C could not be located for August 2015. The administrator, DON (director of nursing) and nurse consultant were made aware in a meeting with the survey team on 03/09/16 at 10:20 a.m. and was asked for assistance in locating the above mentioned lab test. At approximately 9:30 a.m., the corporate nurse consultant voiced that she had called the laboratory and that the HgbA1C was not completed for Resident # 8 in August 2015. No further information or documentation was provided prior to the exit conference on 03/09/16 at 4:00 p.m.	F 502	Random weekly reviews will be conducted for five (5) residents weekly for three (3) months with physician orders for labs to ensure that labs have been obtained per physician's order. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. April 11, 2016	
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory	F 504		

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F 504	Continued From page 22 services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician order prior to obtaining laboratory services for two of 22 residents in the survey sample: Resident # 3 and Resident # 17. 1. Resident # 3 had bloodwork for a TSH (thyroid stimulating hormone) and a free T4 (indicator of thyroid function) obtained without a physician order. 2. Resident # 17 had bloodwork for a CBC (complete blood count) and a BMP (basic metabolic panel) obtained without a physician order. Findings include: 1. Resident # 1 had lab services obtained without a physician order for a TSH and free T4. Resident # 3 was admitted to the facility 11/7/14 with a readmission date of 6/11/15. Diagnoses for Resident # 3 included, but were not limited to: osteoporosis, aftercare of fractured hip, left above knee amputation, peripheral vascular disease, diabetes, stroke, and dementia. The most recent MDS (minimum data set) was a quarterly review dated 12/2/15. Resident # 3 was assessed as having short term and long term memory problems, and severely impaired in daily decision making skills.	F 504	F504 1. For Resident #3, the physician was notified and orders were obtained for the TSH and Free T4 drawn on 3/3/16. For resident #17, the physician was notified and orders were obtained for the CBC and BMP drawn in November 2015. 2. Residents currently residing in the center that require lab tests have the potential to be affected. A review has been conducted by the DCS/designee for residents who have had lab tests obtained in the last thirty (30) days to ensure that there were physician orders for the lab test. 3. In-servicing will be provided to licensed nurses by the DCS/designee regarding obtaining physician orders for lab tests prior to obtaining lab results. Random weekly reviews will be conducted by the DCS/designee for five (5) residents per week for three (3) months to ensure residents who have labs obtained have physician orders for the lab.	

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F 504	Continued From page 23 The clinical record was reviewed 3/8/16 at 1:30 p.m. The current POS (physician order summary), signed by the physician 3/1/16 included lab orders carried forward from 7/10/15 for "HgbA1c (measures blood sugar control), and BMP (basic metabolic panel) every three months: (March, June, Sept, Dec.)" The POS also included an order carried forward from 10/28/15 for "TSH, freeT4 in 3 months (December)." The lab section of the record was then reviewed. Lab results dated 3/3/16 were located, and included results for BMP, HgbA1c, TSH, and free T4. On 3/8/16 at 2:10 p.m. RN (registered nurse) # 1 was asked about the lab results which included the TSH and free T4. RN # 1 was asked if those two values were to have been included. RN # 1 stated "Let me look at the record to see if there was an updated order." RN # 1 reviewed the record, and stated he did not see an updated order for the labs. RN # 1 then stated "Let me check something." RN # 1 went and retrieved a book with the resident's treatment orders. On the current treatment sheet, both lab orders were printed on the form, and staff had initialed obtaining both labs. RN # 1 then stated "I know what's happened; both orders are on the current TAR (treatment administration record). Someone apparently did both labs and didn't look to see the TSH and free T4 was only to have been done in December 2015. I'm really not sure why it's even still on the TAR and POS; it should have come off since it was a one time order." The administrator, DON, and regional director of clinical services were informed of the above findings during a meeting with facility staff 3/9/16 at 10:30 a.m.	F 504	4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. April 11, 2016	

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F 504	Continued From page 24 No further information was provided prior to the exit conference. 2. Resident # 17 had lab services for a CBC and BMP obtained without a physician order. Resident # 17 was admitted to the facility 3/11/13 with diagnoses to include, but were not limited to: peripheral vascular disease, Alzheimer's disease, cardiovascular disease, and psychotic states. The most recent MDS (minimum data set) was a quarterly review dated 2/24/16 and had Resident # 17 assessed with short term and long term memory problems, and severe impairment in daily decision making skills. The clinical record was reviewed 3/9/16 at 1:30 p.m. The current POS (physician order summary) signed by the physician 2/8/16 included an order for "BMP CBC every 6 months (APR/OCT) [sic]." The lab section of the record was then reviewed, and lab results were located dated for October 2015, and also for November 3, 2015. The ADON (assistant director of nursing) was asked for assistance in locating an order for the labs obtained in November 2015. The ADON said she would review the record and the "thinned" record for the order. On 3/9/16 at 3:15 during a meeting with facility staff, the DON (director of nursing) stated they were still waiting on the pharmacy to look for and send documentation of the order. On 3/9/16 at 3:30 p.m. the ADON told this surveyor "Pharmacy said they cannot find any	F 504		

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F 504	Continued From page 25 record of the order for the labs [done in November 2015]."	F 504		
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 staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for three of 22 residents, Resident #5, Resident #13 and Resident #3. 1. Resident #5's current POS (Physician Order Sheet) was dated 11/01/2015 through 11/30/2015. 2. The SSI (sliding scale insulin) orders for Resident #13 contained conflicting parameters for an extended period of time. 3. Resident #3's POS was not updated regarding current orders for laboratory testing.	F 514	F514 1. For Resident #5 the physician order sheet (POS) was corrected to reflect the correct month. For resident #13 the SSI order was clarified and a new order written to reflect the correct parameters. For resident #3, the physician was notified and the POS was corrected regarding orders for laboratory testing. 2. Residents currently residing in the center have the potential to be affected. The DCS/designee will review POSs for the past thirty (30) days to ensure they have the correct date, that SSI orders reflect the correct parameters and that the laboratory tests are current on the POS. 3. In-servicing will be provided to licensed nurses by the DCS/designee regarding ensuring that the POS has the correct date, that SSI orders reflect the correct parameters and that the laboratory tests are current on the POS.	

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F 514	Continued From page 26 Findings were: 1. Resident #5 was most recently readmitted to the facility on 02/20/2016 with the following diagnoses, but not limited to: Sepsis, pneumonia, Edema, obesity, COPD (chronic obstructive pulmonary disease), CKD (chronic kidney disease), Respiratory failure, Shock liver, depression and anxiety. The most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 12/27/2015. Resident #5 was assessed as having a cognitive summary score of "15", indicating she was cognitively intact. The clinical record was reviewed on 03/08/2016 at approximately 1:15 p.m. The physician order section was reviewed. A POS was observed that contained computer printed information and handwritten information. The computer information was generic check off boxes for resident care and to be filled in per resident. The information included but was not limited to: Diet type, code status, therapies needed, resident name, date of birth, admission date and consults. This information was followed by a blank to be either filled in by the facility staff or checked off as needed. At the bottom of the page was an area "Charting For", this area was completed with computer generated dates of "11/01/15 through 11/30/15". The handwritten information included Resident #5's medication orders, and the areas checked off or filled in beside the computer generated information. Beside the computer generated	F 514	Random weekly reviews will be conducted by the DCS/designee for five (5) residents per week for three (3) months to ensure POSs have the correct date, that SSI orders reflect the correct parameters and that the laboratory tests are current on the POS 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. April 11, 2016	

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F 514	Continued From page 27 "DATE OF ADMISSION" was the handwritten date of "2-20-16". The unit manager, LPN (License Practical Nurse) #3 was asked about the POS at approximately 1:45 p.m. She stated, "Those are the orders for February...we got a whole box of those from the pharmacy that have the November date on them. I called them and told them and they sent me another box." She then went to a cabinet and obtained a full box of POS forms containing only the computer generated information. She stated, "This is the second box they sent. See it has the November dates too...I know the ones on the chart are for February, they have her February admission date and the doctor signed them." LPN # 3 was asked if the dates for the orders should have been changed to reflect the accurate date range. She stated, "Yes, the dates should have been changed by the nurse who did the admission." The DON (director of nursing) and the administrator were notified of the above information during an meeting on 03/09/2016 at approximately 10:30 a.m. No further information was obtained prior to the exit conference on 03/09/2016. 2. The SSI (sliding scale insulin) orders for Resident #13 contained conflicting parameters. Findings were: Resident #13 was most recently readmitted to the facility on 04/18/2015. Her diagnoses included,	F 514		

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F 514	Continued From page 28 but were not limited to: Pelvic fracture, diabetes mellitus, dementia, CAD (coronary artery disease), PVD (peripheral vascular disease), depression and fibula fracture. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/2/2015. Resident #13 was assessed as having a cognitive summary score of "06", indicating severe impairment with her cognitive status. The clinical record was reviewed on 03/08/2016 at approximately 3:00 p.m. The POS (physician order sheet) was reviewed. Resident #13 had orders for SSI (sliding scale insulin) to be given three times per day based on blood sugar parameters. The orders were: "NOVOLOG FLEX PEN PREF [prefilled] SYR [syringe] 100 UNITS/1 ML INSULIN PEN THREE TIMES DAILY- FOR BLOOD SUGAR 150-199 2 UNITS, 200-249 3 UNITS, 250-399 4 UNITS, 300-349 5 UNITS, > [greater than] 349 6 UNITS" Parameters for blood sugars from 300 to 399 were conflicted regarding the number of units of SSI Resident #13 was to receive. MARs (medication administration records) were reviewed from November 2015 through the 03/08/2016. The December MAR had been changed to reflect a SSI range of: "150-199 2 UNITS, 200-249 3 UNITS, 250-299 4 UNITS, 300-349 5 UNITS, >349 6 UNITS" All other MARS reviewed contained the conflicting parameters. In November 2015 Resident #13's blood sugars were recorded in the range of 300 -399 a total of	F 514		

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F 514	Continued From page 29 49 times, January 2016 a total of 27 times, February 2016 24 times and March 2016 three times. SSI insulin dosages varied between the parameters listed on the POS. The ADON (assistant director of nursing) was interviewed on 03/08/2016 at approximately 3:45 p.m. regarding the conflicting SSI orders. She looked back through the clinical record and stated, "I need to check on that, I think pharmacy may have made a mistake." The ADON was asked if the nurse's should have gotten clarification for the order. She stated, "Yes, that should have been corrected." On 03/08/2016 at approximately 4:00 p.m. LPN (licensed practical nurse) #2 was observed at the medication cart outside of Resident #13's room. LPN #2 was asked if she had checked Resident #13's blood sugar. She stated, "Yes, it was 294." LPN #2 was asked how much insulin she would give Resident #13 if her blood sugar reading had been 320. She looked at the MAR and stated, "I would give her 5 units. The order is for 300 -349 give 5 units." LPN #2 was asked to read the entire SSI order. She read the order on the MAR and stated, "Oh, I see what you are talking about. That should probably be 250 to 299 not 399." On 03/09/2016 at approximately 8:30 a.m. the ADON spoke with this surveyor regarding the SSI orders. She stated, "The original order had the correct scale, pharmacy transcribed it incorrectly." The clinical record was reviewed at approximately 8:35 a.m. The SSI orders had been corrected to reflect new SSI orders and physician notification of the transcription error.	F 514		

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F 514	Continued From page 30 The DON (director of nursing) and the administrator were notified of the above information on 03/09/2016 at approximately 10:30 a.m. during a morning meeting. No further information was received prior to the exit conference on 03/09/2016. 3. Resident #3's POS was not updated regarding current orders for laboratory testing. Resident # 3 was admitted to the facility 11/7/14 with a readmission date of 6/11/15. Diagnoses for Resident # 3 included, but were not limited to: osteoporosis, aftercare of fractured hip, left above knee amputation, peripheral vascular disease, diabetes, stroke, and dementia. The most recent MDS (minimum data set) was a quarterly review dated 12/2/15. Resident # 3 was assessed as having short term and long term memory problems, and severely impaired in daily decision making skills. The clinical record was reviewed 3/8/16 at 1:30 p.m. The current POS (physician order summary), signed by the physician 3/1/16 included lab orders carried forward from 7/10/15 for "HgbA1c (measures blood sugar control), and BMP (basic metabolic panel) every three months: (March, June, Sept, Dec.)" The POS also included an order carried forward from 1028/15 for "TSH, freeT4 in 3 months (December)." The lab section of the record was then reviewed. Lab results dated 3/3/16 were located, and included	F 514		

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F 514	Continued From page 31 results for BMP, HgbA1c, TSH, and free T4. On 3/8/16 at 2:10 p.m. RN (registered nurse) # 1 was asked about the lab results which included the TSH and free T4. RN # 1 was asked if those two values were to have been included. RN # 1 stated "Let me look at the record to see if there was an updated order." RN # 1 reviewed the record, and stated he did not see an updated order for the labs. RN # 1 then stated "Let me check something." RN # 1 went and retrieved a book with the resident's treatment orders. On the current treatment sheet, both lab orders were printed on the form, and staff had initialed obtaining both labs. RN # 1 then stated "I know what's happened; both orders are on the current TAR (treatment administration record). Someone apparently did both labs and didn't look to see the TSH and free T4 was only to have been done in December 2015. I'm really not sure why it's even still on the TAR and POS; it should have come off since it was a one time order." The administrator, DON, and regional director of clinical services were informed of the above findings during a meeting with facility staff 3/9/16 at 10:30 a.m. No further information was provided prior to the exit conference.	F 514		

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