MontVue Healthcare Center
30 MontVue Drive
Luray, VA 22835
540-743-4571

August 26, 2016

Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive – Suite 401
Henrico, Virginia 23233-1485
Attn: Wietske G. Weigel-Delano, LTC Supervisor

LTC Supervisor,

Enclosed is the Plan of Correction for revisit of survey ending August 4, 2016.

I would like to take this opportunity to thank you for your interest in helping us to improve the care rendered to the residents of our facility.

Sincerely,

Renee Stroud

Renee Stroud
Administrator

COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

Office of Licensure and Certification

TYY 7-1-1 OR
1-800-828-1120

9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
FAX: (804) 527-4502

August 16, 2016

Ms. Renee Stroud, Administrator
Montvue Nursing Home
30 Montvue Drive
Luray, VA 22835

RE: Montvue Nursing Home
Provider Number 495255

Dear Ms. Stroud:

An unannounced standard survey, ending August 4, 2016, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. No complaints were investigated during the survey.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of F), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Wietske G Weigel-Delano, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at "http://www.vdh.state.va.us/OLC/longtermcare/".

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).

- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,

- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: "http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Wietske G. Weigel-Delano

Wietske G Weigel-Delano, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman
Jaime Desper, D M A S (Sent Electronically)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTVUE NURSING HOME	30 MONTVUE DRIVE LURAY, VA 22835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 8/2/16 through 8/4/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 120 certified bed facility was 98 at the time of the survey. The survey sample consisted of 17 current resident reviews (Residents #1 through #17) and five closed record reviews (Residents # 18 through # 22).

F 252 SS=D 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

F 252

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to maintain a clean, comfortable, homelike environment for one of 57 rooms in the facility, room 217

Facility staff failed to replace torn wallpaper and peeling wallpaper and failed to repair a hole in the wall in room 217.

The findings include:

F 252
SAFE/CLEAN/COMFORTABLE/
HOMELIKE ENVIROMENT

I.Renovation of room #217 completed on 08/22/16. All wallpaper was removed the hole in the wall repaired and all walls painted: to reflect a homelike environment.

II. Rounds of resident rooms will be completed on a weekly basis by the Director of Environmental Services or designee. Any repair issues will be reported to the Director of Maintenance via completion of a maintenance ticket.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Renee Strand	Administrator	Aug 26, 2016

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 252	Continued From page 1	F 252	III. Pertinent staff will be in-serviced on the importance of reporting any repair issues of concerns. A review of usage and location of maintenance tickets will be completed. IV. All maintenance tickets received by the maintenance department will be logged and the administrator will f/u with the Director of maintenance bi-weekly to discuss repair issues and plans for completion 09/16/16	

An observation of room 217 was made on 8/4/16 at 10:00 a.m. with OSM (other staff member) #4, maintenance staff. On the wall on the right side of the room was an area approximately 1-1/2 feet wide and three feet long with wallpaper torn off exposing bare wall. On the right wall near the torn wallpaper was a 1-1/2 inch by three inch hole. The wallpaper was peeling away from the seams on the right and left walls in the room. OSM #4 stated, "I'll need to strip and paint that whole wall (indicating the right wall). I think I can patch the other (indicating the peeling wallpaper on the walls)." When asked how often they inspect the rooms, OSM #4 stated, "Very seldom." When asked how maintenance staff were notified of rooms requiring repair, OSM #4 stated, "Housekeeping checks the rooms and let us know." When asked if he had been notified of the condition of room 217, OSM #4 stated that he had not. OSM #4 stated, "We do PM (preventative maintenance), we check the rooms, I haven't got in to check on them yet." When asked why maintenance repaired residents' rooms, OSM #4 stated, "When something is broken it's very inconvenient for the resident and employees, I grant you that don't look good. We try for a homelike feeling as much as possible."

An observation was made on 8/4/16 at 10:05 a.m. with OSM #5, the director of housekeeping. When asked the process staff followed regards to rooms requiring repair, OSM #5 stated, "We'd write it up on a maintenance slip. They're aware of this room." When asked when this was reported to maintenance, OSM #5 stated she did not remember but would check her log where

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F 252	Continued From page 2	F 252		

staff documented that room 217 required repairs. When asked why staff cared about the condition of the rooms, OSM #5 stated that if this was her home she wouldn't want this and the residents shouldn't either since this is their home. A copy of the maintenance form created on 5/2/16 at 10:05 a.m. documented, "Nature of request: Wall paper is peeling and hole in wall beside 216 A bed. Job Status. Date Started: 5-3-16. Job Completed: (a check box) Yes (check box) No (were blank). Parts/Materials Used: Reported hole in wall and wallpaper to (name of controller) to get repaired with (name) painter."

An interview was conducted at 8/4/16 at 11:00 a.m. with ASM (administrative staff member) #1, the administrator and ASM #2, the director nursing. When asked why they repaired residents rooms, ASM #1 stated, "Absolutely, we care." ASM #2 stated, "It's their home, would you approve of it if it was your home?" ASM #1 stated, "The issue is they don't want to repair it because they're going to remodel that room." When asked when the remodeling was scheduled, ASM #1 stated, "We don't know, we haven't heard anything yet." When asked if the residents needed to live in a room in such disrepair, ASM #1 did not respond.

Review of the facility's policy titled, "Preventive Maintenance Program." did not evidence documentation regarding resident room inspections.

F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS — F 281

The services provided or arranged by the facility must meet professional standards of quality.

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F 281	Continued From page 3	F 281	F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 22 residents in the survey sample, Resident #7.

The facility staff failed to transcribe a physician order into the computer system to print on the MAR (medication administration record) for Resident #7, thus the resident did not get her blood sugars completed as ordered.

The findings include:

Resident #7 was admitted to the facility on 10/30/15 with diagnoses that included but were not limited to: dementia, cellulitis, peripheral vascular disease, diabetes, high blood pressure, asthma, and depression.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 7/22/16, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except moving on the unit and bathing for which she was coded as being totally dependent upon staff.

Review of the clinical record revealed a physician order dated, 8/1/16, for "Accu checks BID (finger stick blood sugars twice a day)."

I. Resident #7's physician orders have been reviewed and are correct on the current MAR.

II. All residents requiring glucose monitoring have the potential to be affected by this proposed deficient practice.

III. Licensed nursing staff were in-serviced on 08/25/16 regarding proper procedures on transcribing physician orders to the EHR.

IV. Unit Managers will review physician orders on the redline report to ensure orders have been transcribed correctly. This will be reviewed weekly X 4 weeks, then monthly x 3 months and results to be reviewed at QA for continued compliance.

09/16/16

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F 281	Continued From page 4	F 281		

Review of the MAR (medication administration record) and TAR (treatment administration record) did not reveal any documentation of any blood sugars for 8/2/16 and 8/3/16.

An interview was conducted with LPN (licensed practical nurse) #1 on 8/3/16 at 3:31 p.m. When asked if Resident #7 had blood sugars checked twice a day, LPN #1 stated, "Yes, I took off that order on Monday." When asked where it was documented, LPN #1 reviewed the electronic medical record and stated, "It's not there, it says it was d/c'd (discontinued)." LPN #1 could not locate the results of the blood sugars for 8/2/16 and 8/3/16. After reviewing the clinical record further, LPN #1 stated, "I didn't designate it to go onto the MAR so it wasn't put on the MAR. That's my mistake."

The facility policy, "Implementing Physician's Orders" documented, "The licensed nurse is to insure that there is a proper patient care order from a dully authorized prescriber prior to the administration of any prescription or non-prescription medication or activity that requires such order in accordance with accepted standards of practice and in compliance with the board's regulations. Procedure: Licensed nurses accept, verify, transcribe and implement orders from dully authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, preprinted order sets electronic) in emergent and non-emergent situations. Licensed nurses will ensure infrastructure is in place, consistent with stands of care, to minimize error. Patient safety must be reflected in practices that are specific to the setting and circumstance. Determination of individual client/resident/patient allergy must be

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F 281	Continued From page 5 included in each situation. The nurse is accountable for ensuring that any orders he or she implements are reasonable based on the knowledge of that particular patients care needs at the time and must also ensure the orders are established protocols of the facility. It is the implementing nurse's responsibility for assuring the order is appropriate, accurate and complete." According to Perry & Potter's Fundamentals of Nursing, 6th edition, page 419, "The physician should write all orders, and then nurse must make sure that they are transcribed correctly." The administrative staff members (ASM) #1, the administrator and ASM #2, the director of nursing were made aware of these findings on 8/3/16 at 5:22 p.m. When asked what professional standard the facility uses to base their practice on, ASM #1 stated, "I have no idea. I can't give an answer to that." No further information was provided prior to exit.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that	F 309		

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F 309	Continued From page 6	F 309		

the facility staff failed to follow the physician's orders for three of 22 residents in the survey, sample, Resident #12, #6 and #7.

1. The facility staff failed to increase the dose of Resident #12 ' s Levemir (1) (a long acting insulin to treat diabetes) by 6 (six) units weekly until fasting blood sugar was consistently less than 140, as ordered by the physician.

2.a. The facility staff failed to correctly administer Levemir insulin to Resident #6 per physician's order on 6/24/16 and 7/18/16. The physician's order documented to administer 20 units each night and administer an additional four units each Monday until the resident's blood sugar was less than 150. On 6/24/16 and 7/18/16 an additional four units was administered to the resident although the resident's blood sugars had been less than 150.

b. The facility staff failed to administer the medication Invokamet to Resident #6 on 5/3/16, 5/4/16, 6/17/16 and 6/23/16, per physician's order.

3. The facility staff failed to obtain physician ordered blood sugars for Resident #7.

The findings include:

1. The facility staff failed to increase the dose of Resident #12 ' s Levemir (1) (a long acting insulin to treat diabetes) by 6 (six) units weekly until fasting blood sugar was consistently less than 140, as ordered by the physician.

Resident #12 was admitted to the facility on

F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

I.
- Resident #12's Levimir order has been reviewed and corrected.
- Resident#6's Levemir order has been reviewed and clarified.
- Cannot be corrected, medication was not administered as prescribed.
- Resident #7's physician order for glucose monitoring was clarified and transcribed into the MAR.

II. All residents with physician orders for medications used to treat diabetes and glucose monitoring have the potential to be affected by this proposed deficient practice.

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F 309	Continued From page 7 8/3/12 with diagnoses that included, but were not limited to; depression, cardiovascular disease (a disease affecting the vessels in the heart), chronic obstructive pulmonary disease, high blood pressure and diabetes. Resident #12's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 7/22/16. Resident #12 was coded on the MDS as having a BIMs (Brief Interview for Mental Status) score of 15 out of 15. The MDS manual documents that a score of 15 indicates that the resident's cognition is intact. A review of Resident #12's clinical record revealed, in part, the following order; "Increase Levemir by 6 (six) units weekly until fasting blood sugar less 140 consistently. Schedule Every week on Thursday at 7:00 p.m. Original Order Date: 5/5/2016. Renew 6/23/16." This order was signed by the physician on 6/23/16. A review of Resident #12's MAR (medication administration record) revealed, in part, fasting blood sugars and the dates when Levemir was not increased by 6 units as ordered by the physician: Between 5/19/16 and 5/26/16 blood sugars were documented as 461, 186, 109, 162, 216, 184 and 189 (6 days greater than 140). Between 6/10/16 and 6/16/16 blood sugars were documented as 147, 81, 241, 108, 170, 236 and 208, (5 days greater than 140), Levemir was not increased by six units as ordered. Between 7/22/16 and 7/28/16 blood sugars were documented as 201, 253, 196, 195, 231, 172 and 146 (7 days greater than 140). Levemir was not increased by six units as ordered.	F 309	III. Licensed Nursing Staff will be in-serviced on order entry and correlating documentation. They will also be in-serviced on protocol for ordering medication from the pharmacy. IV. Unit managers will review medication documentation records for any missing administrations for all residents receiving PO and subcutaneous medications for the treatment of diabetes. Random audits of residents with orders for glucose monitoring will be completed to ensure orders are being followed. Record reviews and audits will be done weekly x 4 weeks, then monthly x 3 months. Unit managers will review the findings at the Quarterly QA meeting until substantial compliance is reached. 09/16/16	

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F 309	Continued From page 8	F 309		

Further review of Resident #12's clinical record revealed laboratory test results for a Hgb (hemoglobin) A1C (2) completed on 12/8/15 with a result of 8.2 (the reference range is 2.0 - 4.0) and another Hgb A1C completed on 6/9/16 with a result of 9.8 (the reference range is 2.0 - 4.0).

A review of the physician visit notes for Resident #12 revealed a note written on 6/2/16 which did not reveal any documentation regarding a review of Resident #12's daily fasting blood sugars.

A review of Resident #12's nursing progress notes did not reveal any documentation regarding the Levemir not being increased as ordered on 5/26/16, 6/16/16 and 7/28/16.

A review of Resident #12's comprehensive care plan dated 8/15/12 with a review date of 8/3/16 revealed, in part, the following documentation; "Problem: Diabetes Mellitus: Potential for elevated blood glucose level secondary to diagnosis of IDDM (insulin dependent diabetes mellitus). Goals: (Name of Resident #12) blood sugar will be monitored as ordered qd (every day). Interventions: Blood sugar monitored as ordered."

On 8/3/16 at approximately 2:30 p.m. an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked to review the order for Resident #12 to increase Levemir by six units one time per week if the blood sugars were consistently greater than 140. LPN #7 stated, "Once a week we will look at the week prior to the review date and if the blood sugars are greater than the parameter provided then we would increase the Levemir as ordered." LPN #7 was asked what the word "consistently" meant as

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written in the physician order. LPN #7 stated that it meant that if the blood sugars were over the parameter more than half the time.

At an end of day meeting on 8/3/16 at 5:20 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the concerns and that a nurse was in the process of reviewing all the blood sugars for Resident #12 and the increases in Levemir. At this time a policy was requested regarding blood sugar tracking and insulin administration.

On 8/4/16 at 8:20 a.m. an interview was conducted with RN (registered nurse) #1. RN #1 was shown the order to increase Resident #12's Levemir by six units when his prior weeks blood sugars were consistently greater than 140. RN #1 stated that the order was not followed as ordered. RN #1 was asked what nursing should have done on 5/26/16, 6/16/16 and 7/22/16. RN #1 stated that the Levemir should have been increased on each one of those dates and it was not done. RN #1 was asked what the word "consistently" meant as written in the order. RN #1 stated, "If I was to look at it I would review the blood sugars and if the majority (greater than half) the blood sugars were greater than 140 I would increase the Levemir." RN #1 was asked if this interpretation was understood by all nursing staff that needed to make the decision regarding the increase for Levemir. RN #1 stated, "I don't know. It is an unclear order; we should have got clarification from the physician or the nurse practitioner."

On 8/4/16 at 9:05 an interview was conducted with ASM #4, Resident #12's physician and the

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facility medical director. ASM #4 was asked about the order for Resident #12 which stated to increase Levemir by six units if the blood sugars were consistently greater than 140 in a week. ASM #4 stated, "I don't want the sugars high, if we increase by six units each week it works, if the nurses are reviewing them their acumen (ability to make good judgments and quick decisions) should be able to make the right decision." ASM #4 was advised that the order had not been followed as ordered on 5/26/16, 6/16/16 and 7/22/16. ASM #4 stated, "The order is vague for people who don't understand, it depends on the readers' understanding of the order. I guess the right thing to do would be to look at it and just do a steady dose. The order is vague and I wrote the order. I should have gone over it."

On 8/4/16 at 11:00 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked to review the order for increasing Levemir by six units. ASM #2 reviewed the order and stated it was an unclear order. ASM #2 was asked if the order was unclear what should have happened. ASM #2 stated it should have been clarified. ASM #2 was asked who was responsible for reviewing Resident #12's blood sugars; ASM #2 stated that the nursing staff was responsible for reviewing the blood sugars to determine the correct the dose of Levemir. ASM #2 was asked whether or not that had been done each week since the order was prescribed, ASM #2 stated that it had not been done as ordered.

A review of the facility policy titled "Implementing Physician Orders" revealed, in part, the following documentation; "Purpose: To guide the practice of RN or LPN when accepting, verifying and

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transcribing patient care orders from a duly authorized prescriber. Policy: The licensed nurse is to insure that there is a proper patient care order from a dully (sic) authorized prescriber prior to the administration of any prescription or non-prescription medication or activity that requires such order in accordance with accepted standards of practice. Procedure: The nurse is accountable for ensuring that any orders he or she implements are reasonable based on the knowledge of that particular patients (sic) care needs at the time and must also ensure the orders are established protocols of the facility. It is the implementing nurses' responsibility for assuring the order is appropriate, accurate and complete

A review of the facility policy titled "Policy and Procedure Monitoring of Resident Blood Glucose Levels" Policy: Residents Blood Glucose levels will be monitored as ordered by the Attending Physician. Procedure: 1. Residents will receive blood glucose monitoring as ordered by the attending physician. 2. Nurse will document the blood glucose monitoring on the residents Medication Administration Record.

No further information was provided prior to the end of the survey process.

1. Levemir (insulin detemir) is a man-made form of insulin, a hormone that is produced in the body. Insulin works by lowering levels of glucose (sugar) in the blood. Insulin detemir is a long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours. Levemir is used to improve blood sugar control in adults and children with diabetes mellitus. This information was obtained from the

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following website :<https://www.drugs.com/mcd/diabetes>.

2. The A1C test measures what percentage of your hemoglobin - a protein in red blood cells that carries oxygen - is coated with sugar (glycated). The higher your A1C level, the poorer your blood sugar control and the higher your risk of diabetes complications. This information was obtained from the following website: https://www.google.com/search?q=hgb+a1c&biw=1067&bih=545&source=lnms&sa=X&ved=0ahUKEwiBu8-1_rHOAhUG5iYKHYVCAHkQ_AUIBSgA&dpr=1.2
In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419 "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

2.a. The facility staff failed to correctly administer Levemir insulin (1) to Resident #6 per physician's order on 6/24/16 and 7/18/16. The physician's order documented to administer 20 units each night and administer an additional four units each Monday until the resident's blood sugar was less than 150. On 6/24/16 and 7/18/16 an additional four units was administered to the resident although the resident's blood sugars had been less than 150.

Resident #6 was admitted to the facility on 4/26/13. Resident #6's diagnoses included but were not limited to: diabetes, high blood pressure and atrial fibrillation (2). Resident #6's most recent MDS (minimum data set), a significant

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change in status assessment with an ARD (assessment reference date) of 4/27/16, coded the resident as being cognitively intact.

Review of Resident #6's clinical record revealed a physician's order dated 6/6/16 for "Levemir 100 units/ml (milliliter)- inject 20 units by subcutaneous route once daily at bedtime; add four units each Monday until FBS (fasting blood sugar) less than 150 constantly."

Resident #6's comprehensive care plan with an effective date of 5/2/16 documented, "Problem: DIABETES MELLITUS: IDDM (insulin dependent diabetes mellitus). Resident has elevated blood glucose level secondary to diagnosis of IDDM...Interventions: Administer medications as ordered..."

Review of Resident #6's June 2016 MAR (medication administration record) revealed the resident was administered 24 units of Levemir on 6/24/16 although the resident's blood sugars were:
101 on 6/17/16
142 on 6/18/16
130 on 6/19/16
109 on 6/20/16
143 on 6/21/16
140 on 6/22/16
114 on 6/23/16
117 on 6/24/16.

Review of Resident #6's July 2016 MAR revealed the resident was administered 24 units of Levemir on 7/18/16 although the resident's blood sugars were:
96 on 7/11/16
119 on 7/12/16

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F 309	Continued From page 14 99 on 7/13/16 130 on 7/14/16 109 on 7/15/16 109 on 7/16/16 114 on 7/17/16 98 on 7/18/16 On 8/3/16 at 1:58 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was shown Resident #6's Levemir order. LPN #7 was asked how nurses should follow the order. LPN #7 stated on Mondays, nurses should look back at the resident's blood sugars and add four units of insulin if the blood sugars are consistently over 150. LPN #7 was asked what "consistently" meant. LPN #7 stated if the resident's blood sugar was greater than 150 four out of the last seven days then the extra four units of insulin should be given. LPN #7 was shown Resident #6's blood sugars and asked if the extra insulin should have been given. LPN #7 stated, "No. They (the blood sugars) are consistently less than 150." On 8/3/16 at 3:53 p.m., an interview was conducted with LPN #10 (the nurse responsible for administering Levemir to Resident #6 on 6/24/16 and 7/18/16). LPN #10 was shown Resident #6's Levemir order. LPN #10 was asked how nurses should follow the order. LPN #10 stated she thought the order would be discontinued when the resident's blood sugars were consistently less than 150. LPN #10 stated she had looked at Resident #6's blood sugars for the last three or four days (prior to administering Levemir) and the blood sugars were not consistently low and were in the 200s. LPN #10 was shown Resident #6's blood sugars for the last week prior to dates when she administered	F 309		

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the extra four units. LPN #10 stated she didn't remember the situation and she didn't care for the resident every single day.

On 8/3/16 at 5:30 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

On 8/4/16 at 9:10 a.m., an interview was conducted with ASM #4 (Resident #6's physician). ASM #4 stated the Levemir order should have documented to give four extra units on Mondays if the resident's blood sugar was consistently (not constantly) less than 150. ASM #4 stated he wrote consistently (not constantly) in his writing. ASM #4 was asked what "consistently" meant. ASM #4 stated nurses should look at the resident's blood sugars for the last week and he was happy if the resident's blood sugars were less than 150 on most days. ASM #4 was made aware of the above interviews with nurses. ASM #4 was shown Resident #6's blood sugars/MARs and ASM #4 stated the extra insulin should not have been given. ASM #4 stated, "I guess it's my fault because I wrote an order that was subject to too much interpretation."

The facility policy titled, "IMPLEMENTING PHYSICIANS ORDERS" documented, "PROCEDURE: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e. written, verbal/telephone, standing orders/protocols, preprinted order sets, electronic) in emergent and non-emergent situations. Licensed nurses will ensure infrastructure is in place, consistent with standards of care, to minimize error..."

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No further information was presented prior to exit.

(1) Levemir insulin is used to treat diabetes. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d38d65c1-25bf-401d-9c7e-a2c3222da8af

(2) Atrial Fibrillation is a problem with the rhythm or speed of the heartbeat. This information was obtained from the website: https://medlineplus.gov/atrialfibrillation.html

b. The facility staff failed to administer the medication Invokamet (1) to Resident #6 on 5/3/16, 5/4/16, 6/17/16 and 6/23/16, per physician's order.

Review of Resident #6's clinical record revealed a physician's order dated 5/3/16 for Invokamet 150/500 milligrams twice daily. The order was entered into the computer system as a general order instead of a medication order. Review of Resident #6's May and June 2016 MARs (medication administration records) revealed the Invokamet was not administered to Resident #6 on 5/3/16, 5/4/16, 6/17/16 and 6/23/16. On 5/3/16 the MAR documented, "NOH (not on hand) pharm (pharmacy) called ordered." On 5/4/16 the MAR documented, "NOH." On 6/17/16 the MAR documented, "NOH. Pharmacy aware now." On 6/23/16 the MAR documented, "Ordered from pharmacy."

Resident #6's comprehensive care plan with an effective date of 5/2/16 documented, "Problem: DIABETES MELLITUS: IDDM (insulin dependent

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diabetes mellitus). Resident has elevated blood glucose level secondary to diagnosis of IDDM...Interventions: Administer medications as ordered..."

On 8/3/16 at 1:58 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated every nurse on every shift is responsible for keeping an eye on the medication supply and if a nurse notices five pills left then he/she should reorder the medication.

On 8/3/16 at 2:30 p.m., an interview was conducted with RN (registered nurse) #3 (the nurse who documented the 5/3/16 and 5/4/16 notes on the MARs). RN #3 stated she reorders medication when five pills are left. RN #3 was asked what "NOH" meant. RN #3 stated it meant "not on hand." RN #3 was shown Resident #6's May 2016 MAR and asked why Invokamet wasn't administered to the resident on 5/3/16 and 5/4/16. RN #3 stated the medication was a new order that the physician had just written. RN #3 stated the pharmacy had to order the medication because they didn't have it in stock.

On 8/3/16 at 3:25 p.m., another interview was conducted with LPN #7 (the nurse who documented the 6/17/16 note on the MAR). LPN #7 was shown Resident #6's June 2016 MAR and asked why Invokamet wasn't administered to the resident on 6/17/16. LPN #7 stated the order was originally typed into the computer system as a general order instead of a medication order. LPN #7 stated the pharmacy didn't receive orders that weren't put into the computer system as medication orders. LPN #7 stated the nurse had to call the pharmacy to get the medication when it was originally ordered and there was no way to

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refill the medication through the computer system because the medication was entered as a general order.

On 8/3/16 at 4:19 p.m., an interview was conducted with LPN #8. LPN #8 stated if an order was entered into the computer as a general order instead of a medication order, then the medication could not be refilled through the computer system. LPN #8 stated the order would have to be faxed to the pharmacy.

The nurse who documented the 6/23/16 note on Resident #6's MAR was no longer employed at the facility.

On 8/3/16 at 5:30 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. Policies regarding the above concern were requested.

On 8/4/16 at 9:35 a.m., LPN #8 was asked to provide further pharmacy documentation and any further information to explain why Resident #6's Invokamet was not given.

On 8/4/16 at 11:15 a.m., ASM #1 and ASM #2 were asked to provide any further pharmacy documentation regarding Resident #6's Invokamet.

On 8/4/16 at 11:46 a.m., LPN #8 presented documentation from the pharmacy. The documentation revealed a physician's hand written order dated 5/2/16 for Invokamet 150/500 milligrams twice daily. The documentation revealed this order was not faxed to the pharmacy until 5/4/16. The pharmacy

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documentation further revealed sixty tablets of Invokamet was filled and sent to the facility on 6/3/16 (therefore, enough medication should have been at the facility for administration on 6/17/16 and 6/23/16).
At this time, LPN #8 confirmed Resident #6's Invokamet order was entered into the computer system as a general order. LPN #8 stated the pharmacy would not have received the order because it was entered as a general order instead of a medication order. LPN #8 stated a fax order would have had to been sent to the pharmacy.

The facility policy titled, "IMPLEMENTING PHYSICIANS ORDERS" documented, "PROCEDURE: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e. written, verbal/telephone, standing orders/protocols, preprinted order sets, electronic) in emergent and non-emergent situations. Licensed nurses will ensure infrastructure is in place, consistent with standards of care, to minimize error..."

(1) Invokamet is used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a613033.html

3. The facility staff failed to obtain physician ordered blood sugars for Resident #7.

Resident #7 was admitted to the facility on 10/30/15 with diagnoses that included but were

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not limited to: dementia, cellulitis, peripheral vascular disease, diabetes, high blood pressure, asthma, and depression.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 7/22/16, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except moving on the unit and bathing for which she was coded as being totally dependent upon staff.

Review of the clinical record revealed a physician order dated, 8/1/16, for "Accu checks BID (finger stick blood sugars twice a day)."

Review of the MAR (medication administration record) and TAR (treatment administration record) did not reveal any documentation of any blood sugars for 8/2/16 and 8/3/16.

An interview was conducted with LPN (licensed practical nurse) #1 on 8/3/16 at 3:31 p.m. When asked if Resident #7 had blood sugars checked twice a day, LPN #1 stated, "Yes, I took off that order on Monday." When asked where it was documented, LPN #1 reviewed the electronic medical record and stated, "It's not there, it says it was d/c'd (discontinued)." LPN #1 could not locate the results of the blood sugars for 8/2/16 and 8/3/16. After reviewing the clinical record further, LPN #1 stated, "I didn't designate it to go onto the MAR so it wasn't put on the MAR. That's my mistake."

An interview was conducted with administrative

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staff member (ASM) #3, the nurse practitioner, on 8/3/16 at 3:38 p.m. When asked if she had ordered blood sugars on Resident #7, ASM #3 stated, "Yes. I had spoken to the daughter and the resident had been on Metformin (used to treat diabetes (1)). I had no recent blood sugars and her Hgb (hemoglobin) A1C (blood test to determine blood sugar levels over a period of time (2)) were a bit low for this age group. I wanted to see where she was with her blood sugars in hopes of possibly discontinuing the Metformin in the future."

An interview was conducted with RN (registered nurse) #1, the unit manager, on 8/3/16 at 3:48 p.m. When asked if there is a physician order for blood sugars twice a day, what is the expectation of the nurse caring for that resident, RN #1 stated, "They are usually ordered either at 6:00 a.m. and 4:00 p.m. or 8:00 a.m. and 4:00 p.m. depending on the doctor's order and the resident's preference. Unless otherwise ordered, the nurse is to do the blood sugars as ordered."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 8/3/16 at 4:36 p.m. When asked if a physician has ordered blood sugars to be done twice a day, what is the expectation of the nursing staff, ASM #2 stated, "They should do them." When asked where they are documented, ASM #2 stated, "In this facility they are documented on the MAR."

The administrator and ASM #2 were made aware of the above findings on 8/3/16 at 5:22 p.m.

No further information was provided prior to exit.

(1) http://livertox.nih.gov/Metformin.htm

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(2)
https://www.niddk.nih.gov/health-information/diabetes/diagnosis-diabetes-prediabetes/a1c-test

F 329 SS=D 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a resident was free of unnecessary medication for one of 22

F 329

F 329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

I. Cannot correct medication already administered.

II. Any resident with an order for insulin has the potential to be affected by the proposed deficient practice.

III. Licensed nursing staff will be in-serviced on requesting clarification on any orders that have the potential for variable interpretations. Licensed nursing staff will also be in-serviced on the importance of reviewing, resident glucose records prior to giving insulin.

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residents in the survey sample, Resident #6.

The facility staff failed to correctly administer Levemir insulin (1) to Resident #6 per physician's order on 6/24/16 and 7/18/16. The physician's order documented to administer 20 units each night and administer an additional four units each Monday until the resident's blood sugar was less than 150. On 6/24/16 and 7/18/16 an additional four units was administered to the resident although the resident's blood sugars had been less than 150.

The findings include:

Resident #6 was admitted to the facility on 4/26/13. Resident #6's diagnoses included but were not limited to: diabetes, high blood pressure and atrial fibrillation (2). Resident #6's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 4/27/16, coded the resident as being cognitively intact.

Review of Resident #6's clinical record revealed a physician's order dated 6/6/16 for "Levemir 100 units/ml (milliliter)- inject 20 units by subcutaneous route once daily at bedtime; add four units each Monday until FBS (fasting blood sugar) less than 150 constantly."

Resident #6's comprehensive care plan with an effective date of 5/2/16 documented, "Problem: DIABETES MELLITUS: IDDM (insulin dependent diabetes mellitus). Resident has elevated blood glucose level secondary to diagnosis of IDDM...Interventions: Administer medications as ordered..."

IV. Unit managers will utilize redline report to verify that no new orders require further clarification from MD/FNP. Unit managers will complete random audits of residents with insulin orders to ensure that insulin is being administered according to MD/FNP orders. Audits will be done weekly x 4 weeks, then monthly x 3 months. Findings will be reviewed in QA to see if audits will need to be continued to reach substantial compliance. 09/16/16

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Review of Resident #6's June 2016 MAR (medication administration record) revealed the resident was administered 24 units of Levemir on 6/24/16 although the resident's blood sugars were:
101 on 6/17/16
142 on 6/18/16
130 on 6/19/16
109 on 6/20/16
143 on 6/21/16
140 on 6/22/16
114 on 6/23/16
117 on 6/24/16.

Review of Resident #6's July 2016 MAR revealed the resident was administered 24 units of Levemir on 7/18/16 although the resident's blood sugars were:
96 on 7/11/16
119 on 7/12/16
99 on 7/13/16
130 on 7/14/16
109 on 7/15/16
109 on 7/16/16
114 on 7/17/16
98 on 7/18/16

On 8/3/16 at 1:58 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was shown Resident #6's Levemir order. LPN #7 was asked how nurses should follow the order. LPN #7 stated on Mondays, nurses should look back at the resident's blood sugars and add four units of insulin if the blood sugars are consistently over 150. LPN #7 was asked what "consistently" meant. LPN #7 stated if the resident's blood sugar was greater than 150 four out of the last seven days then the extra four units of insulin should be given. LPN #7 was

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shown Resident #6's blood sugars and asked if the extra insulin should have been given. LPN #7 stated, "No. They (the blood sugars) are consistently less than 150."

On 8/3/16 at 3:53 p.m., an interview was conducted with LPN #10 (the nurse responsible for administering Levemir to Resident #6 on 6/24/16 and 7/18/16). LPN #10 was shown Resident #6's Levemir order. LPN #10 was asked how nurses should follow the order. LPN #10 stated she thought the order would be discontinued when the resident's blood sugars were consistently less than 150. LPN #10 stated she had looked at Resident #6's blood sugars for the last three or four days (prior to administering Levemir) and the blood sugars were not consistently low and were in the 200s. LPN #10 was shown Resident #6's blood sugars for the last week prior to dates when she administered the extra four units. LPN #10 stated she didn't remember the situation and she didn't care for the resident every single day.

On 8/3/16 at 5:30 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

On 8/4/16 at 9:10 a.m., an interview was conducted with ASM #4 (Resident #6's physician). ASM #4 stated the Levemir order should have documented to give four extra units on Mondays if the resident's blood sugar was consistently (not constantly) less than 150. ASM #4 stated he wrote consistently (not constantly) in his writing. ASM #4 was asked what "consistently" meant. ASM #4 stated nurses should look at the resident's blood sugars for the

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last week and he was happy if the resident's blood sugars were less than 150 on most days. ASM #4 was made aware of the above interviews with nurses. ASM #4 was shown Resident #6's blood sugars/MARs and stated the extra insulin should not have been given. ASM #4 stated, "I guess it ' s my fault because I wrote an order that was subject to too much interpretation."

The facility policy titled, "IMPLEMENTING PHYSICIANS ORDERS" documented, "PROCEDURE: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e. written, verbal/telephone, standing orders/protocols, preprinted order sets, electronic) in emergent and non-emergent situations. Licensed nurses will ensure infrastructure is in place, consistent with standards of care, to minimize error..."

The facility policy titled, "Insulin Administration and Documentation" documented, "Procedure: Check the MAR to insure (sic) you have the right type of insulin. Also, make sure of the time, the amount and the route of the dose..."

No further information was presented prior to exit.

(1) Levemir insulin is used to treat diabetes. This information was obtained from the website: <https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=d38d65c1-25bf-401d-9c7e-a2c3222da8af>

(2) Atrial Fibrillation is a problem with the rhythm or speed of the heartbeat. This information was obtained from the website: <https://medlineplus.gov/atrialfibrillation.html>

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F 364 SS=C	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364	F 364 NUTRITIVE VALUE/APPER, PALATIVE/PREFER TEMP	

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, and staff interview, it was determined that facility staff failed to serve food at a palatable temperature.

Facility staff failed to serve hot food at the 8/3/16 lunch service.

The findings include:

A group interview was conducted on 8/2/16 with nine cognitively intact residents who stated that the food temperatures were cold.

Three months of Resident Council Minutes were reviewed and there were no complaints of cold food.

On 8/3/16 at 11:10 food temperatures were obtained by OSM (other staff member) #7, the dietary aide, prior to serving the food and were documented as follows: baked chicken - 150 degrees; ground chicken - 162 degrees; rice- 170 degrees; stir fried vegetables - 165 degrees; potatoes with cheese - 180 degrees; tomatoes with zucchini - 170 degrees; pureed chicken = 132 degrees; pureed tomatoes - 165 degrees; pureed potatoes with cheese - 170 degrees; green beans - 170 degrees; vegetable soup - 175

I. Unable to correct due to all trays already being served before the tray audit.

II. All residents have the potential to be affected by this proposed deficient practice.

III. The plate warmer will be replaced to ensure all plates are warm prior to being placed in the cart. Both units will have at least one CNA available to assist the hospitality aides in handing out the trays at meals.

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degrees; chicken noodle soup - 180 degrees; extra potatoes with cheese - 180 degrees. At this time OSM #7, was asked what the holding temperatures for food were. OSM #7 responded, "145 degrees or higher."

On 8/3/16 at 11:30 this surveyor observed the dietary staff preparing the food service trays for the residents in the facility. All residents were provided a tray for meals. At 12:10 p.m. a test tray was requested to be placed on the last cart and to be served after all residents had been served from that cart. The last cart was delivered to the north wing hall at 12:20 p.m. The last tray was served to two surveyors at 12:40. Temperatures were obtained by OSM #8, a dietary manager, and observed by OSM #2, a dietary manager. The temperature of the food served on the last tray were as follows: tomatoes and zucchini - 115 degrees; stir fry with rice - 120 degrees; vegetable soup - 102 degrees; potatoes with cheese - 120 degrees mechanical chicken - 96 degrees; chicken - 110 degrees; green beans - 106 degrees; chicken noodle soup - 110 degrees; pureed chicken - 98 degrees; pureed tomatoes with zucchini - 80 degrees; pureed potatoes - 80 degrees. All foods on the test tray were tasted by two members of the survey team and OSM #8. The food was cool tasting. OSM #8 was asked whether or not the temperature of the foods was palatable. OSM #8 responded, "I would like it better if it were warmer." OSM #8 was asked what the expectation was for the temperature of food served to the residents. OSM #8 responded, "It should be served at around 145 degrees."

On 8/3/16 at 1:10 p.m. an interview was conducted with OSM #7, the dietary aide. OSM

IV. Dietary managers will complete random tray audits at various meals. Audits will be done weekly x 4 weeks, then monthly x 3 months. Findings will be reviewed at QA until substantial compliance is met. 09/16/16

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#7 was asked her process for temping foods. OSM #7 responded that she obtained temperatures of the food when they came out of the oven and then within 15 minutes of serving. OSM #7 was asked what temperature the food should be at when served to the residents, OSM #7 responded, "The food should be served to the resident at the holding temperature of 145 degrees." OSM #7 was provided the temperatures of the food obtained prior to serving and asked about the pureed chicken which temped at 132 degrees. OSM #7 stated she did recheck the temperature of the pureed chicken one more time prior to serving. OSM #7 was not observed obtaining a second temperature prior to serving and OSM #7 did not provide the temperature obtained the second time. OSM #7 was asked about the can of tomato soup that was heated for a specific resident request. OSM #7 responded that the soup was heated in the microwave. OSM #7 was asked if she obtained a temperature of the food prior to serving, OSM #7 responded, "I don't temp the soup, we have temped before but I don't do it every time, we just know that if you microwave for 1.5 minutes its fine." OSM #7 was asked whether she knew the temperature of the soup when added to the resident's tray, OSM #7 stated she did not. OSM #7 was asked whether she had any concerns when microwaving food, OSM #7 responded, "There could be hot spots. It could have been too hot or too cold."

A review of the facility policy titled, "Tray line and Meal Service Temperatures" revealed, in part, the following documentation: "Policy: It is (name of facility's) policy to serve food to the patients at the appropriate temperatures, that is, hot food acceptably hot and cold food cold. Procedure: 1.

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all food items that do not register a minimum of 140 degrees F (Fahrenheit) will be returned to the stove and heated until they exceed 140 degrees F."

A review of the facility policy titled "Minimum Temperatures at Point of Service to Patient" revealed, in part, the following documentation; "Procedure: The minimum temperature of the food at point of service to the patient should be: The food item, the Recommended Temp (temperature) at Serving and Minimum Temp at Delivery:
Broth Soup at 165 for serving and > (greater than) 150 at delivery
Potatoes at 180-190 for serving and >120 at delivery
Vegetables at 180-190 for serving and >120 at delivery
Puree Vegetables at 165 for serving and >120 for delivery
Meat at 165 at serving and >120 for delivery
Puree Meat 165 at serving and >120 for delivery.

On 8/3/16 at 5:20 p.m. an end of day meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above findings. No further information was obtained prior to the end of the survey process.

F 371 SS=E 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY F 371

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local

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F 371	Continued From page 31 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY I. a) At the time of survey, pureed dessert trays were moved to lower shelf in the refrigerator, meeting guidelines for covering of food. b) unable to change actions already completed. II. All residents have the potential to be affected by this proposed deficient practice. III. Dietary staff will be in-serviced on proper food storage and sanitary techniques.	

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined facility staff failed to store and serve food in a safe manner.

Facility staff placed one tray of 17 pureed desserts in the tray line refrigerator without any covering and during the food serving process a dietary aide failed to use sanitary technique.

The findings include:

On 8/3/16 at 10:45 a.m. a tour of the kitchen was conducted with OSM (other staff member) #8, the dietary manager. In the tray line refrigerator there was a metal tray on the top shelf which contained 17 bowls containing a pureed dessert. The shelf was at shoulder level and the desserts were uncovered. OSM #8 was asked whether or not the desserts were supposed to be covered, OSM #8 responded, "Yes, they should have been covered with paper and should not have been stored uncovered on the top shelf." OSM #8 showed this surveyor a tray holder beneath the shelves that were covered. OSM #8 stated that the tray of desserts should have been covered with paper and stored on the lower tray holder.

On 8/3/16 at 11:10 a.m. OSM #7, a dietary aide was observed obtaining temperatures on each

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food being served. OSM #7 was wearing gloves throughout the process. OSM #7 was observed during the process to wipe across her mouth with her right gloved hand, OSM #7 did not change her gloves. OSM #7 then put her gloved hand into her pocket to obtain a pen, OSM #7 did not change her gloves. OSM #7 did not clean off the thermometer between obtaining temperatures of chicken, rice and stir fried vegetables. At 11:15 during the process OSM #7 took some trash to the trash can, lifted the trash can lid and did not change her gloves.

On 8/3/16 at 1:10 p.m. an interview was conducted with OSM #7. OSM #7 was asked to describe the process for obtaining temperatures of food. OSM #7 stated, "I wipe the thermometer off with alcohol swabs between foods. I didn't do it today, I forgot, I was nervous." OSM #7 was asked what she should do whenever she touched her clothing or face with her gloved hand. OSM #7 stated, "If you touch your face, you should change your gloves." OSM #7 was informed she was observed touching her face with her gloved hand and placing her hand in her pocket. OSM #7 stated she did not remember doing that. OSM #7 was informed that she was observed lifting the trash can lid with her gloved hand and then returning to the tray line, and continued obtaining temperatures for the food. She did not change her gloves, or wash her hands. OSM #7 stated she thought she had changed her gloves.

The facility policies related to food preparation and food storage did not reference the tray line refrigerator and the storage of food in that refrigerator.

The facility policy titled, "Food Preparation

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IV. Dietary managers will complete a daily audit of desserts to ensure proper storage. Dietary managers will also complete random audit by observation of dietary staff to ensure proper sanitary techniques are being followed. Audits will be completed for 4 weeks. 09/16/16

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Handwashing Procedures" revealed, in part, the following documentation; Policy" It is (name of facility) policy to prevent the transmission of bacteria. Procedure: 1. Hands must be washed: c. After touching your hair or skin."

On 8/3/16 at 5:20 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above findings at this time.

No further information was provided prior to the end of the survey process.

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F 372 SS=F 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY

The facility must dispose of garbage and refuse properly.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined that the facility staff failed to maintain the dumpster in a sanitary manner.

Facility staff failed to repair the leak in the bottom seam of the dumpster and failed to keep the doors to the dumpster closed.

The findings include:

An observation of the facility's dumpster was made on 8/3/16 at 5:00 p.m. with OSM (other staff member) #4, the maintenance staff and another surveyor. There were two dumpsters observed, the dumpster on the right had an eight

F 372

F 372 DISPOSE GARBAGE & REFUSE PROPERLY

I. Dumpsters were replaced on 08/05/16.

II. All residents have the potential to be affected by this proposed deficient practice.

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by eight inch round puddle of greenish liquids with flies on it. Above the puddle there was a rusted area, 1/4 inch wide area approximately 13 inches long, and a drop of liquid was observed falling from the dumpster into the puddle. The sliding door on the front of the dumpster was left open approximately 12 inches. When shown the puddle and leak, OSM #4 stated, "I see the problem, I'll have to call for a new one." OSM #4 pointed to the open area and stated, "We need to make sure the welds are all sealed up." When asked why the dumpster area was kept clean of debris, OSM #4 stated, "We might get a pole cat." When asked if the door of the dumpster should be left open, OSM #4 closed the door and stated, "No".

An interview was conducted on 8/4/16 at 9:55 a.m. with OSM #6, the maintenance director. When asked why the dumpster doors were kept closed, OSM #6 stated, "To keep insects and flies from getting in." When asked why the dumpsters were kept free from debris, OSM #6 stated, "The smell, contamination, it's just plain nasty. It could draw bears or raccoons." A request for the facility's policy on waste management in relationship to dumpster maintenance was requested; OSM #6 stated they did not have a policy.

On 8/4/16 at 10:00 a.m. OSM #4, the maintenance staff stated, "I called the company and we'll have a new dumpster here in about five days."

On 8/4/16 at 10:29 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

III. In-services will be given to dietary, housekeeping and maintenance staff to ensure they are aware to keep the doors of the dumpsters closed at all times to visually inspect for any leaks or corrosion. Any issues of concern are to be reported to the immediate supervisor and if necessary to the administrator.

IV. Maintenance staff will visually inspect the dumpsters and surrounding area monthly, any issues of concern will be reported to the administrator. 09/16/16

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No further information was provided prior to exit.

F 386 SS=D 483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS

The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to write a progress note upon assessment of one of 22 residents in the survey sample, Resident #7.

The nurse practitioner examined Resident #7 on 7/18/16 and did not write a progress note.

The findings include:

Resident #7 was admitted to the facility on 10/30/15 with diagnoses that included but were not limited to: dementia, cellulitis, peripheral vascular disease, diabetes, high blood pressure, asthma, and depression.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 7/22/16, coded the resident as being severely impaired to

F 372

F 386

F 386 PHYSICIAN VISITS-REVIEW CARE/NOTES/ORDERS

I. FNP entered a late entry note on 08/04/16 pertaining to visit 07/18/16 visit.

II. Any resident seen by the FNP has the potential to be affected by the proposed deficient practice.

III. D.O.N. and administrator discussed with FNP the necessity of completing progress notes following assessments of residents. FNP given access to Sigmacare in order to write progress notes in the resident's EHR.

IV. D.O.N. will complete a random audit of FNP visits to ensure documentation is received weekly x 4 weeks and then monthly x 3 months.

09/16/16

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make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except moving on the unit and bathing for which she was coded as being totally dependent upon staff.

A review of the clinical record revealed a nurse's note dated, 7/18/16 that documented, "NP (nurse practitioner) in to see resident this pm (evening) r/t (related to) sore area on (R) (right) buttock. No new orders received."

Review of the clinical record did not reveal any progress note for 7/18/16 from the nurse practitioner.

A request was made on 8/3/16 at approximately 10:30 a.m. for the nurse practitioner note of 7/18/16.

On 8/3/16 at 11:36 a.m. administrative staff member (ASM) #2, the director of nursing, informed this surveyor that she spoke with the nurse practitioner and she informed her that she had seen the resident and told the staff to continue the current treatment but she didn't write a note.

On 8/3/16 at 11:39 a.m. an interview was conducted with ASM #3, the nurse practitioner. When asked if she examined Resident #7's buttocks on 7/18/16, ASM #3 stated, "I did see her buttocks on 7/18/16. I did not write a note. The area was red. I made the daughter aware and encouraged offloading of pressure. I notified the DON (director of nursing) as she has taken the lead on wounds. I can't write a note on every patient I see. I don't have a progress note. If

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there had been an open wound I would have written a note."

An interview was conducted with ASM #2 on 8/3/16 at 4:36 p.m. When asked should a doctor or nurse practitioner document a progress note when they have examined a resident and made a decision on care, ASM #2 stated, "I would think so. It's nursing practice to write a note if you assess a resident, I would think it would be the same if a nurse practitioner or physician assessed a resident for care."

A policy was requested on the physician/nurse practitioner's responsibility for writing progress notes.

The facility policy, "Dr. (doctor) Visits and Recert Notes" documented, "Physician visits must be documented in the resident record Progress Notes section when a Resident is seen. The visit and Re-certification notes must then be either on the Residents medical record or scanned/typed into the Residents Electronic Health Record no later than 10 days following the date of the visit."

The administrator and ASM #2 were made aware of the above findings on 8/3/16 at 5:22 p.m.

No further information was provided prior to exit.

F 387 SS=E 483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT

The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

F387 FREQUENCY & TIMELINESS
F 387 OF PHYSICIAN VISIT

I. Resident #8, 12, 18, 9 have received timely physician visits for their current certification period.

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A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure timely physician visits for four of 22 residents in the survey sample, Residents #9, #12, #18 and #8.

1. The facility staff failed to ensure timely physician visits for Resident #9. The resident was not seen by the physician from 3/23/16 through 6/10/16, a period of 79 days.

2. The facility staff failed to ensure that Resident #12 was seen by a physician between 8/22/15 and 12/3/15, a period of 103 days.

3. The facility staff failed to ensure that Resident #18 had a physician visit between 8/29/15 to 2/13/16, a total of 167 days, a 107 days longer than the required 60 days. There was no physician visit between 2/13/16 to 6/27/16, a total of 134 days, 74 days longer than the required 60 days.

4. The facility staff failed to ensure timely physician visits for Resident #8. The resident was not seen by the physician from 4/7/16 through 7/15/16, a period of 98 days.

The findings include:

1. The facility staff failed to ensure timely physician visits for Resident #9. The resident

II. All residents in the building as of 08/16/16 will be reviewed for timely physician visits. Physicians will be made aware of any resident visits out of compliance.

III. As needed, the physician/NP will be notified of upcoming re-certifications due dates 10 days before, 5 days before, on the date, and 5 days after the compliance due date. All correspondence with MD/NP will be documented with date, time and manner of notification.

IV. Current monitoring tool will be adjusted to include receipt of physician note to EHR.
If physician has not completed necessary visit by date of compliance, administrator or designee will be notified.

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was not seen by the physician from 3/23/16 through 6/10/16, a period of 79 days.

Resident #9 was admitted to the facility on 7/11/15. Resident #9's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 6/29/16, coded the resident's cognition as being severely impaired.

Review of Resident #9's clinical record failed to reveal evidence that Resident #9 was seen by the physician from 3/23/16 through 6/10/16 (a total of 79 days).

On 8/3/16 at 3:09 p.m., an interview was conducted with OSM (other staff member) #1, medical records manager and unit secretary, (the person responsible for tracking physician visits). OSM #1 stated residents receiving Medicaid should be seen by the physician every 60 days and she tracks physician visits in her book. OSM #1 stated Resident #9 was due to be seen by the physician on 4/2/16 but was seen 3/23/16 instead. OSM #1 stated the physician didn't see the resident again until 6/10/16 but the physician should have seen the resident before that date. OSM #1 stated there was a transition period where Resident #9's current physician took over for a previous physician. OSM #1 stated, "We had a few (physician visits) that were late and (name of current physician) tried to catch up."

On 8/3/16 at 5:30 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Policy on Documentation

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Of Physician Visits" documented, "Physician visits will be tracked by the Medical Records person using a log to record dates re-certification is due for a resident, the date that the physician sees the resident, and the date that the progress note is received in the facility, if the physician dictates his note at resident's bedside. If the progress note is not received seven days after the physician visit, the medical records clerk will call the physician's office for the progress note. If the physician dictates his note at resident's bedside, a notation and signature will be made in the progress notes that a dictated note is to follow. Physicians visits will be documented in the nurse's notes with the date, time, and purpose of visit by the nurses on the units."

The facility policy titled, "Dr. Visits and Recert Notes" documented, "Physician visits must be documented in the resident record Progress Notes section when a Resident is seen. The visit and Re-certification notes must then be either on the Residents medical record or scanned/typed into the Residents Sigma Care Electronic Health Record no later than 10 days following the date of the visit."

No further information was presented prior to exit.

2. The facility staff failed to ensure that Resident #12 was seen by a physician between 8/22/15

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and 12/3/15, a period of 103 days.

Resident #12 was admitted to the facility on 8/3/12 with diagnoses that included, but were not limited to; depression, cardiovascular disease (a disease affecting the vessels in the heart), chronic obstructive pulmonary disease, high blood pressure and diabetes.

Resident #12's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 7/22/16. Resident #12 was coded on the MDS as having a BIMs (Brief Interview for Mental Status) score of 15 out of 15. The MDS manual documents that a score of 15 indicates that the resident's cognition is intact.

A review of Resident #12's clinical record did not reveal a physician visit between 8/22/15 and 12/2/15, a total of 102 days.

On 8/3/16 at 3:10 p.m. an interview was conducted with OSM (other staff member) #1, medical records manager and unit secretary. OSM #1 was asked how frequently the physician was required to see a resident in the facility. OSM #1 stated, "The physician must see a Medicaid resident every 60 days." OSM #1 was asked how she made sure that the physician visits were timely, OSM #1 stated that she tracked the physician visits in a log. OSM #1 provided the log for review. OSM #1 was asked if Resident #12 was seen by a physician or nurse practitioner between 8/22/15 and 12/15. OSM #1 stated, "Resident #12 was not seen, the visit was missed."

An end of day meeting was conducted on 8/3/16

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at 5:20 p.m. with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above findings.

No further information was provided prior to the end of the survey process.

3. Facility staff failed to ensure that Resident #18 had a physician visit between 8/29/15 to 2/13/16, a total of 167 days, a 107 days longer than the required 60 days. There was no physician visit between 2/13/16 to 6/27/16, a total of 134 days, 74 days longer than the required 60 days.

Resident #18 was admitted to the facility on 12/31/10 and readmitted on 1/11/13 with diagnoses that included but were not limited to: diabetes, adjustment disorder, high blood pressure, chronic obstructive lung disease and elevated lipids.

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/25/16 coded the resident as being a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as needing the assistance of one staff member for bathing and toileting.

Review of the physician progress notes documented that the patient received a physician's visit on 8/29/15. The next documented visit was on 2/13/16, a total of 167 days between visits, 107 days longer than the required 60 days. The next documented visit was on 6/27/16, a total of 134 days between visits, 74 days longer that the required 60 days.

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On 8/4/16 at 10:15 a.m. a request was made to OSM (other staff member) #1, (medical records manager and unit secretary), for the physician progress notes for Resident #18 for the dates between 8/29/15 and 2/13/16 and between 2/13/16 and 6/27/16.

An interview was conducted on 8/4/16 at 10:35 a.m. with OSM #1, medical records and unit secretary. OSM #1 stated she did not have progress notes during those time periods and stated, "I talked to him (the doctor) about it and I called the office and they don't have any (notes).) I know he sees her all the time, but there's no note." When asked what the requirement for physician visits was, OSM #1 stated, "Sixty days." When asked how physician visits were tracked, OSM #1 stated, "I track the MD (medical doctor) visits every month, I let the doctor know they (the residents) need to be seen. I email them. Once I email them (the list of residents to be visited) to the office then there's a folder on each nurses' station and it's labeled, "recert (recertification) folder" for them (physicians') to use when they come in and I keep a copy of it (the recertification folder) on my desk so there's copies everywhere." When asked what process she used regarding late physician notes, OSM #1 stated, "I would talk to the medical director if his visits were late, but I did not talk to him if other doc's (doctors) visits were late." When asked who was ultimately responsible for ensuring that the physician's visited on a regular basis, OSM #1 wasn't sure.

An interview was conducted on 8/4/16 at 11:00 a.m. with ASM (administrative staff member) #1, the administrator. When asked who was ultimately responsible for ensuring physician visits

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were completed in a timely manner, ASM #1 stated, "Well, she's (OSM #1) been following them and she notifies them (the doctors) when they're due and if it's ten days late she notifies them again." When asked who in the facility had the ultimate responsibility to ensure physician's visits were completed in a timely manner, ASM #1 stated, "What I would say is if I know about it I'd take care of it but I haven't heard of anything."

No further information was provided prior to exit.

4. The facility staff failed to ensure timely physician visits for Resident #8. The resident was not seen by the physician from 4/7/16 through 7/15/16, a period of 98 days.

Resident #8 was admitted to the facility on 3/25/14 with diagnoses that included but were not limited to: stroke, gastroesophageal reflux disease, depression, anxiety disorder, high blood pressure, chronic obstructive pulmonary disease, heart failure, psychosis, and pain.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/16/16, coded the resident as scoring a 9 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as being independent in moving in the bed, transfers, walking in the room, eating, toileting, and personal hygiene. The resident was coded as requiring supervision for moving on the unit,

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dressing, and bathing.

Review of the clinical record, revealed a physician progress note dated, 4/7/16. There were no further physician or nurse practitioner notes, dated after this date.

On 8/3/16 at 12:30 p.m. a request was made to LPN (licensed practical nurse) #2 for any physician progress notes dated after 4/7/16.

On 8/3/16 at 1:28 p.m. an interview was conducted with LPN (licensed practical nurse) #2, the staff development nurse. When asked who tracks the physician visits, LPN #2 stated, "(Name of the medical records staff member)."

On 8/3/16 at 1:47 p.m. LPN #2 stated that they could not locate any physician progress note after 4/7/16 for Resident #8.

On 8/3/16 at 3:59 p.m. an interview was conducted with other staff member (OSM) #1, the unit secretary, medical records staff member. When asked to explain why there were no physician progress notes after 4/7/16 for Resident #8, OSM #1 stated, "We were transitioning from one doctor to another." When asked if there was a period when they were not seen, OSM #1 stated, "Yes." When asked if the medical director should have been contacted to inform him that the resident had not been seen, OSM #1 stated, "Yes, I should have contacted him but I didn't. I need to focus more on physician progress notes and recerts (recertification's)."

On 8/3/16 at 4:30 p.m. an interview was conducted with administrative staff member (ASM) #2, the director of nursing. When asked

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MONTVUE NURSING HOME	30 MONTVUE DRIVE LURAY, VA 22835

(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 387	Continued From page 46 how often a resident is to be seen by the physician, ASM #2 stated, "Quarterly, once a month." When asked if she was sure of that, ASM #2 stated, "No, I'd have to check on that and get back with you." Administrative staff member (ASM) #1, the administrator and ASM #2 were made aware of the above concern on 8/3/16 at 5:22 p.m. On 8/4/16 a copy of a nurse practitioner note dated 7/15/16 was presented to this surveyor. No further information was provided prior to exit.	F 387		
F 425 SS=D	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. 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.	F 425	F 425 PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH I. Cannot be corrected, medication not administered as ordered II. All residents have the potential to be affected by the same deficient practice. III. Licensed Nursing Staff will be in-serviced on protocol to re-order medications from pharmacy when only a 5 day supply is remaining.	

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F 425	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review the facility staff failed to ensure physician ordered medication was available for administration for one of 22 residents in the survey sample, Resident #6. The facility staff failed to ensure Resident #6's medication Xarelto (1) was available for administration as ordered on: 5/30/16, 5/31/16 and 6/1/16. The findings include: Resident #6 was admitted to the facility on 4/26/13. Resident #6's diagnoses included but were not limited to: diabetes, high blood pressure and atrial fibrillation (2). Resident #6's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 4/27/16, coded the resident as being cognitively intact. Review of Resident #6's clinical record revealed a physician's order dated 4/15/16 for Xarelto 10 mg (milligrams) - one tablet by mouth every day with evening meal. Review of Resident #6's May and June 2016 MARs (medication administration records) revealed the medication was not administered on 5/30/16, 5/31/16 and 6/1/16. On 5/30/16 the MAR documented the medication was not given because it was not on hand and the pharmacy was aware. On 5/31/16 the MAR documented the medication was not administered because it was not on hand. The MAR further documented the pharmacy was contacted and	F 425	IV. D.O.N. or designee will review medication re-order list and pharmacy delivery manifest 3x week to ensure that medications have been delivered as requested. If there are medications not delivered, D.O.N. or designee will contact pharmacy and present discrepancies to QA Committee. 09/16/16	

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F 425	Continued From page 48	F 425		

the medication was due to arrive that night. On 6/1/16 the MAR documented the medication was not administered because it was not on hand.

Resident #6's comprehensive care plan with an effective date of 5/3/13 documented, "Problem: ANTICOAGULATION THERAPY: Potential for Bleeding...Interventions: Administer anticoagulant therapy as per MD order..."

On 8/3/16 at 1:58 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated every nurse on every shift is responsible for keeping an eye on the medication supply and if a nurse notices five pills left then he/she should reorder the medication.

On 8/3/16 at 2:30 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated she reorders medication when five pills are left.

On 8/3/16 at 3:35 p.m., an interview was conducted with LPN #9 (the nurse who documented the 5/30/16 note on Resident #6's MAR). LPN #9 stated she reorders medication when a four day supply is left. LPN #9 stated normally the pharmacy processes the order and sends the medication the next day. LPN #9 was shown Resident #6's MAR. LPN #9 stated evidently the resident didn't have any of the medication on 5/30/16. LPN #9 stated she called the pharmacy and was told the medication was coming on the night run.

The nurse who documented the 5/31/16 and 6/1/16 notes on Resident #6's MARs was no longer employed at the facility.

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F 425	Continued From page 49 On 8/4/16 at approximately 9:35 a.m., LPN #8 presented pharmacy documentation that documented the Xarelto refill was entered into the system on 5/30/16 at 5:40 p.m. and the medication was "manifested" (put into a delivery bag) on 6/1/16 at 5:56 p.m. The facility pharmacy products and services agreement documented in part, "1. RESPONSIBILITIES OF PHARMACY: 1.1 General: During the term of this Agreement, Pharmacy shall: a. provide Pharmacy Products to Facility and its residents in a prompt and timely manner in accordance with Applicable Law ..." (1) Xarelto is used to prevent/treat blood clots. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a611049.html	F 425		
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.	F 514		

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F 514 Continued From page 50

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of 22 residents in the survey sample, Resident #12, #6 and #7.

1. The facility staff failed to document blood sugar values for Resident #12 on eight occasions in March 2016.

2. The facility staff failed to accurately document the amount of Levemir insulin given to Resident #6 on 5/28/16 and 5/29/16.

3. The nurse practitioner examined Resident #7 on 7/18/16 and did not write a progress note.

The findings include:

1. The facility staff failed to document blood sugar values for Resident #12 on eight occasions in March 2016.

Resident #12 was admitted to the facility on 8/3/12 with diagnoses that included, but were not limited to; depression, cardiovascular disease (a disease affecting the vessels in the heart), chronic obstructive pulmonary disease, high blood pressure and diabetes.

Resident #12's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 7/22/16. Resident #12 was coded on the MDS as having a BIMs (Brief Interview for Mental Status) score of 15 out of 15. The MDS manual documents that a

F 514

F 514 RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

I. a) unable to correct documentation error for previous dates.

b) unable to correct documentation error for previous dates.

c) FNP entered a late entry note on 08/04/16 pertaining to 07/15/16 visit.

II. a&b) all residents receiving glucose monitoring and insulin administration have the potential to be affected.

c) all residents seen by FNP have the potential to be affected.

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score of 15 indicates that the resident's cognition is intact.

A review of Resident #12's clinical record revealed, in part, the following physician order; "FSBS (finger stick blood sugar) at 630 (6:30) AM and 8 PM may give PRN (as needed) glucagon (used to raise the concentration of glucose in the bloodstream) if FSBS is below 50. Monitoring: Blood Sugar Start Date: 3/2/2016 8:00 P.M." Further review of Resident #12's clinical record revealed a "Resident Medication Administration Record" for March 2016 that revealed, in part, that on the following dates the staff failed to obtain a FSBS as ordered; 3/3/16 at 8:00 p.m.; 3/4/16 at 8:00 p.m.; 3/7/16 at 8:00 p.m.; 3/12/16 at 8:00 p.m.; 3/13/16 at 8:00 p.m.; 3/14/16 at 8:00 p.m.

On 8/4/16 at 8:20 a.m. an interview was conducted with RN (registered nurse) #1. RN #1 was asked to review the March 2016 medication administration record (MAR) for Resident #12, specifically the FSBS order and completion at 6:30 a.m. and 8:00 p.m. RN #1 reviewed the MAR and stated that the nurse had failed to record the blood sugars as ordered. RN #1 stated, "I think they were done because they were signed off on as being done but they failed to document the result. They are supposed to document the blood sugar result each shift." RN #1 stated, "The clinical monitoring was not attached to the order so the nurse was not prompted to enter the blood sugar." RN #1 was asked what should have happened, RN #1 stated that the nurse should have documented in the progress notes and had someone fix the order.

On 8/4/16 at 11:00 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2

III. a) Licensed nurses will be in-serviced to document blood sugar values in the clinical monitoring section of the EHR.

b) Licensed nurses will be educated in proper documentation of insulin on EHR.

c) D.O.N. & administrator discussed with FNP the necessity of completing progress notes upon assessment of residents.

IV. a&b) Unit managers will complete random audits of residents with glucose monitoring & insulin orders to ensure the BS values & insulin administered are documented correctly.

c) D.O.N. will complete a random audit of FNP visits to ensure documentation is received weekly x 4 weeks then monthly x 3 months.

09/16/16

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was provided the March MAR for Resident #12 and shown the missing blood sugar results. ASM #2 stated, "The nursing staff is responsible for documenting the blood sugars when obtained."
A review of the facility policy titled, "Monitoring of Resident Blood Glucose Levels" revealed, in part, the following information; "Policy: Residents Blood Glucose levels will be monitored as ordered by the Attending Physician. Procedure: 2. Nurse will document the blood glucose monitoring on the residents Medication Administration Record."
No further information was provided prior to the end of the survey process.

2. The facility staff failed to accurately document the amount of Levemir insulin (1) given to Resident #6 on 5/28/16 and 5/29/16.

Resident #6 was admitted to the facility on 4/26/13. Resident #6's diagnoses included but were not limited to: diabetes, high blood pressure and atrial fibrillation (2). Resident #6's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 4/27/16, coded the resident as being cognitively intact.

Review of Resident #6's clinical record revealed a physician's order dated 5/16/16 for Levemir 100 units/milliliter- inject 16 units by subcutaneous route once daily at bedtime; add four units each Monday until fasting blood sugar was constantly less than 150. Review of Resident #6's May 2016 MAR (medication administration record)

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revealed documentation that only four units of Levemir was administered to Resident #6 on 5/28/16 and 5/29/16.

On 8/4/16 at 8:22 a.m., an interview was conducted with RN (registered nurse) #2 (the nurse who documented administration of four units of insulin to Resident #6 on 5/28/16). RN #2 was shown Resident #6's MAR. RN #2 stated, "It says I gave four (units). I am always good about reading it (physician's orders on the MAR)." RN #2 stated she gave the correct amount of insulin but inaccurately documented the amount given.

On 8/4/16 at 10:41 a.m., an interview was conducted with LPN (licensed practical nurse) #5 (the nurse who documented administration of four units of insulin to Resident #6 on 5/29/16). LPN #5 was shown Resident #6's MAR. LPN #5 stated, "It says I gave four (units) but that was a typo. I gave 16."

On 8/4/16 at 11:15 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. A policy regarding the above findings was requested.

The facility policy titled, "Monitoring of Resident Blood Glucose Levels" documented in part, "6. If insulin is ordered, based on a sliding scale, Document the type and amount of insulin administered and the site of the injection..."

No further information was presented prior to exit.

(1) Levemir insulin is used to treat diabetes. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf

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(2) Atrial Fibrillation is a problem with the rhythm or speed of the heartbeat. This information was obtained from the website: https://medlineplus.gov/atrialfibrillation.html

3. The nurse practitioner examined Resident #7 on 7/18/16 and did not write a progress note.

Resident #7 was admitted to the facility on 10/30/15 with diagnoses that included but were not limited to: dementia, cellulitis, peripheral vascular disease, diabetes, high blood pressure, asthma, and depression.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 7/22/16, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except moving on the unit and bathing for which she was coded as being totally dependent upon staff.

A review of the clinical record revealed a nurse's note dated, 7/18/16 that documented, "NP (nurse practitioner) in to see resident this pm (evening) r/t (related to) sore area on (R) (right) buttock.

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No new orders received."

Review of the clinical record did not reveal any progress note for 7/18/16 from the nurse practitioner.

A request was made on 8/3/16 at approximately 10:30 a.m. for the nurse practitioner note of 7/18/16.

On 8/3/16 at 11:36 a.m. administrative staff member (ASM) #2, the director of nursing, informed this surveyor that she spoke with the nurse practitioner and she informed her that she had seen the resident and told the staff to continue the current treatment but she didn't write a note.

On 8/3/16 at 11:39 a.m. an interview was conducted with ASM #3, the nurse practitioner. When asked if she examined Resident #7's buttocks on 7/18/16, ASM #3 stated, "I did see her buttocks on 7/18/16. I did not write a note. The area was red. I made the daughter aware and encouraged offloading of pressure. I notified the DON (director of nursing) as she has taken the lead on wounds. I can't write a note on every patient I see. I don't have a progress note. If there had been an open wound I would have written a note."

An interview was conducted with ASM #2 on 8/3/16 at 4:36 p.m. When asked should a doctor or nurse practitioner document a progress note when they have examined a resident and made a decision on care, ASM #2 stated, "I would think so. It's nursing practice to write a note if you assess a resident, I would think it would be the same if a nurse practitioner or physician

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assessed a resident for care."

A policy was requested on the physician/nurse practitioner's responsibility for writing progress notes.

The facility policy, "Dr. (doctor) Visits and Recert Notes" documented, "Physician visits must be documented in the resident record Progress Notes section when a Resident is seen. The visit and Re-certification notes must then be either on the Residents medical record or scanned/typed into the Residents Electronic Health Record no later than 10 days following the date of the visit."

The administrator and ASM #2 were made aware of the above findings on 8/3/16 at 5:22 p.m.

No further information was provided prior to exit.

State of Virginia

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F 000	Initial Comments	F 000		

An unannounced biennial State Licensure Inspection was conducted 8/2/16 through 8/4/16. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.

The census in this 120 certified bed facility was 98 at the time of the survey. The survey sample consisted of 17 current resident reviews (Residents #1 through #17) and five closed record reviews (Residents # 18 through # 22).

F 001 Non Compliance

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
12VAC5-371-140. Policies and procedures.

Based on staff interview, it was determined that the facility staff failed to conduct an annual review of all policies and procedures.

The findings include:

On 8/2/16 at 10:45 a.m., during the entrance conference, ASM (administrative staff member) #1 (the administrator) was asked to provide evidence of annual review for all facility policies and procedures.

On 8/4/16 at 10:15 a.m., ASM #1 was given a list of all policy and procedure reviews that were needed.

On 8/4/16 at 10:05 p.m. ASM #1 stated she had evidence of an annual review for the policies and procedures regarding nursing services, dietary

F 001 F 001 NON COMPLIANCE

I. P&P regulated by state guidelines will be reviewed.

II. All residents have the potential to be affected.

III. Review of Facility P&P manuals will be completed annually

IV. SDC will verify that all P&P manuals are reviewed annually. 09/16/16

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

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F 001	Continued From Page 1	F 001		

services, quality assurance, infection control, safety and maintenance. ASM #1 stated she did not have evidence that all other policies and procedures had been reviewed. A policy regarding the above findings was requested.

No further information was presented prior to exit.

12VAC5-371-240. Physician services cross reference to F387.

12 VAC 5 - 371 - 200 - B. 1 cross references to F 281

12 VAC 5 - 371 - 240 - E cross references to F 386
12VAC5-371-250 Resident Assessment and Care Planning is cross referenced with F309

12VAC5-371-340 Dietary and Food SErvices is cross referenced with F364 and F371

12VAC5-371-140 Policies and Procedures is cross referenced with F387 and F514

12VAC5-371-370.A. cross references to F 252

12VAC5-421-2640. Outside receptacles.A.B. cross references to F372