STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E076	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNYDER NURSING HOME	11 NORTH BROAD ST SALEM, VA 24153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/8/16 through 11/10/16. 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 45 certified bed facility was 44 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents 1 through 10) and 1 closed record review (Resident 11).	F 000	F 278 483.20(g – (i) Assessment Accuracy/Coordination/Certified. Snyder Nursing Home maintains, in accordance with accepted professional standards and practices, that resident assessments accurately reflect the resident status.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278	On November 11, 2016 a facility Incident Report was filed on behalf of Resident #7 seeking clarification from the Interdisciplinary Care Plan Team pertaining to the identification of Mood Disorders; MDS 3.0 Section D. On November 11, 2016 Resident #7's Medical Record and Minimum Data Set was reviewed by the Director of Nursing and the Interdisciplinary Care Plan Team. It was determined that assessments prior to and after the Annual Assessment with an ARD date of April 12, 2016 had been completed.	11/11/16 11/11/16

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kerk A I	Administrator	11/25/16

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

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F 278	Continued From page 1	F 278		

penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) assessment for 1 of 11 residents (Resident #7).

The findings included:

The facility staff failed to ensure Section D Mood of the annual minimum data set (MDS) assessment was accurate for Resident #7. The staff assessment of resident mood was inaccurate with dash marks used to identify symptoms present and symptom frequency.

The clinical record of Resident #7 was reviewed 11/8/16 and 11/9/16. Resident #7 was admitted to the facility 9/8/2011 with diagnoses that included but not limited to major depressive disorder, mild cognitive impairment, anemia, hyperlipidemia, hypothyroidism, osteoarthritis, macular degeneration, and osteoporosis.

Resident #7's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/12/16 assessed the resident with a brief interview for mental status score of 9 out of 15.

Section D Mood was reviewed. Section D0500 Staff Assessment of Resident Mood was noted to

F 278 483.20(g – (i) Assessment Accuracy/Coordination/Certified Continued.

On November 16, 2016 an audit of Section D of all MDS assessments for the period 11/14/15 thru 11/16/16 was completed by the MDS/Care Plan Coordinator. Any omissions identified were given to the Interdisciplinary Care Plan Team for review and compliance.

11/16/16

To prevent the reoccurrence of this type of deficiency, the Director of Nursing or Designee will perform a monthly MDS Compliance Audit for three months and then randomly for two months. At a minimum, 25% of all resident MDS will be audited. This audit will include a review of Section D of The MDS titled "Identification of Mood Disorders". Any records not in compliance will be identified and the responsible staff will be counseled in accordance with established facility policy. This will be will be an ongoing QA/QI Measure

ONGOING QA/QI MEASURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 2	F 278	F 278 483.20(g – (i) Assessment Accuracy/Coordination/Certified Continued.	

have dash marks for both symptom presence and symptom frequency for the following: A. Little interest or pleasure in doing things B. Feeling or appearing down, depressed, or hopeless D. Feeling tired or having little energy. F. Indicating that s/he feels bad about self, is a failure, or has let self or family down G. Trouble concentrating on things, such as reading the newspaper or watching television I. States life isn't worth living, wishes for death, or attempts to harm self J. Being short-tempered easily annoyed.

The surveyor interviewed the minimum data set (MDS) registered nurse on 11/9/16 at 9:00 a.m. about Section D. The MDS RN stated social services was responsible for completing Section D.

The surveyor interviewed the social worker/activities director on 11/9/16 at 9:10 a.m. The Social Worker reviewed Section D and stated she didn't interview any staff. The social worker stated she charted what she observed. She also stated she didn't remember using the dash marks. The social worker stated she could observe Resident #7 eating and could complete that part. The social worker stated Resident #7 was difficult to assess. The surveyor asked to see the interview/answers from the staff assessments. The social worker stated she didn't have any.

The surveyor informed the director of nursing and the administrator of the inaccuracy of Section D on Resident #7's annual MDS during the end of the day meeting on 11/9/16 at 3:00 p.m.

No further information was provided prior to the exit conference on 11/10/16.

To prevent the reoccurrence of this type of deficiency, Facility policy and procedure pertaining to Accuracy, coordination and certification of the MDS were reviewed by the Director of Nursing, Medical Director, Administrator and the Interdisciplinary Care Plan Team. This review was completed on 11/15/2016. 11/15/16

To prevent the reoccurrence of this type of deficiency, all Care Plan Team members will receive additional training and education pertaining to the accuracy, coordination and certification of the MDS. This training will be conducted by the Director of Nursing or her designee and Silver Chair Learning. This training will be completed by 11/30/2016. 11/30/16

To prevent the reoccurrence of this type of deficiency, the Facility Quality Assurance/Quality Improvement Team will review the results of the monthly MDS audits. This will be an ongoing QA/QI measure. on going QA/QI measure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514	F 514 483.75(l) (1) RES Records-Complete/Accurate/Accessible.	

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 2 of 11 residents (Resident #7 and Resident #8).

The findings included:

1. The facility staff failed to document the reason a urinalysis was obtained from the physician's standing orders for Resident #7.

The clinical record of Resident #7 was reviewed 11/8/16 and 11/9/16. Resident #7 was admitted to the facility 9/8/2011 with diagnoses that included but not limited to major depressive disorder, mild cognitive impairment, anemia, hyperlipidemia, hypothyroidism, osteoarthritis, and macular degeneration, and osteoporosis.

Resident #7's annual minimum data set (MDS)

Snyder Nursing Home maintains, in accordance with accepted professional standards and practices, a complete, accurately documented readily accessible and systematically organized clinical record for each resident.

On November 11, 2016 a Facility Incident Report was filed on behalf of Resident #7 and Resident #8 seeking clarification pertaining to reasons for urinalysis with reflex culture + sensitivities.

11/11/16

On November 11, 2016 the clinical records of all current residents were audited by the Director of Nursing and the MDS Care Plan Coordinator. The audit focused on nursing documentation supporting the need for Physician ordered urinalysis with reflex culture + sensitivities within the past 90 days. It was determined that no other urinalyses were obtained without appropriate supporting documentation.

11/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 4	F 514	F 514 483.75(l) (1) RES Records-Complete/Accurate/Accessible.	

assessment with an assessment reference date (ARD) of 4/12/16 assessed the resident with a brief interview for mental status score of 9 out of 15.

The laboratory section of the clinical record had the results of a urinalysis obtained on 3/9/16. The surveyor was unable to locate a physician order for the urinalysis.

The surveyor requested the assistance of the director of nursing on 11/9/16 at 10:00 a.m. After reviewing the clinical record, the DON stated the facility had standing orders and the nurse obtained the urine based on those and didn't need to write an order. The surveyor questioned why the urinalysis was obtained. The standing orders for urinalysis read "Lab (routine) (unless otherwise indicated) 11. Urinalysis with reflex culture + sensitivities prn (whenever necessary) for any patient with fever and/or urinary symptoms."

The DON and surveyor reviewed the nurse's notes from 3/8/16 and 3/9/16. The nurse's note dated 3/8/16 6:30 p.m. read "Temperature 97.5, no complaints pain or otherwise, no unusual behaviors or hallucinations." 3/8/16 8:45 p.m. nurse's note read "Urine obtained by I&O (in and out) cath (catheter) using sterile technique for U/A (urinalysis) with reflex culture." 3/9/16 3 a.m. nurse's note read "T (temperature) 96.8, no complaints of urinary discomfort, waiting on UA C&S (culture and sensitivity) results."

The surveyor questioned the director of nursing again regarding the reason for the urinalysis obtained 3/9/16. The DON was unable to locate any evidence why the staff obtained a urinalysis

On November 11, 2016 the Facility Medical Director reviewed Physician Standing Orders. Standing orders pertaining to urinalysis with reflex culture + sensitivities were revised to read "obtain urinalysis with reflex cultures + sensitivities on all new admissions". A physician Order was obtained for all residents requiring urinalysis with reflex culture + sensitivities prn. Nursing to document symptoms.

11/11/16

To prevent the reoccurrence of this type of deficiency, the Director of Nursing or Designee will perform a monthly Lab Study Compliance Audit for three months and then randomly for two months. At a minimum, 25% of all resident records will be audited. This audit will include a review of Physician orders for routine lab studies, as well as, a review of supporting documentation by the license nurse for any urinalysis obtained. Any records not in compliance will be identified and the responsible staff will be counseled in accordance with established facility policy.

on going QA/QI monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 5	F 514		

and culture and sensitivity.

The facility staff failed to document any signs or symptoms why a urinalysis was obtained on Resident #7. Resident #7 did not have a fever or documentation of signs or symptoms of a urinary tract infection.

The surveyor informed the administrator and the director of nursing of the above concern on 11/9/16 at 3:00 p.m.

No further information was provided prior to the exit conference on 11/10/16.

2. The facility staff failed to document the reasons a urinalysis was obtained from the physician's orders for Resident #8.

The clinical record of Resident #8 was reviewed 11/10/16. Resident #8 was admitted to the facility 9/28/16 with diagnoses that included but not limited to displaced fracture of neck of left radius, fall history, osteoarthritis, ulcerative colitis, paroxysmal atrial fibrillation, gastroesophageal reflux disease, Crohn's disease, vascular syndromes of brain, anemia, urinary incontinence, bilateral hearing loss, and Vitamin deficiency.

The admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/6/16 assessed the resident with short term memory issues, long term memory problems, and severe impairment for daily decision making.

The laboratory section of the clinical record had the results of a urinalysis obtained 10/26/16. The

F 514 483.75(l) (1) RES
Records-
Complete/Accurate/Accessible.
Continued.

To prevent the reoccurrence of this type of deficiency, Facility policy and procedure pertaining to Physician ordered Lab Studies were reviewed by the Director of Nursing, Medical Director and Administrator. This review was completed on November 15, 2016.

11/15/16

To prevent the reoccurrence of this type of deficiency, the Facility Pharmacist's monthly audit will include a review of Lab Studies as ordered by the Physician. Any findings or recommendations will be forwarded to the Director of Nursing. This will be an ongoing QA/QI measure.

ongoing QA/QI measure.

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F 514	Continued From page 6	F 514		

surveyor was unable to locate the physician order. The surveyor requested the assistance of licensed practical nurse #2 on 11/10/16 at 8:30 a.m. She reviewed the clinical record and stated she was unable to find a physician order. L.P.N. #2 stated the facility used standing physician orders. The surveyor asked L.P.N. #2 the reason for the urinalysis. L.P.N. #2 stated Resident #8 had had several falls since admission. The surveyor reviewed the nurse's note for 10/26/16. There was one nurse's note for 10/26/16 at 4 a.m. but no reason why the urinalysis had been obtained. The surveyor reviewed the 10/22/16, 10/23/16, and 10/25/16 nurse ' s notes and found no documentation why the urinalysis was obtained.

The standing orders for urinalysis read "Lab (routine) (unless otherwise indicated) 11. Urinalysis with reflex culture + sensitivities prn (whenever necessary) for any patient with fever and/or urinary symptoms." The surveyor asked L.P.N. #2 if falls were listed on the standing orders as a reason to obtain a urinalysis. L.P.N. #2 stated no. There was no documentation that Resident #8 had a fever or signs or symptoms of a urinary infection.

The surveyor informed the administrator and the director of nursing of the above concern in lack of documentation for obtaining a urinalysis on Resident #8 on 11/10/16 at 10:40 a.m. The DON stated she knew why the urinalysis was obtained but stated she failed to document the reason.

No further information was provided prior to the exit conference on 11/10/16.

F 514 483.75(l) (1) RES
Records-
Complete/Accurate/Accessible.
Continued.

To prevent the reoccurrence of this type of deficiency, all licensed Nursing Staff will receive additional training and education pertaining to orders for Routine Lab Studies and Medical Records Documentation. This training will be conducted by the Director of Nursing and Silver Chair Learning. This training will be completed by November 30, 2016.

11/30/16

To prevent the reoccurrence of this type of deficiency, the Facility Quality Assurance/Quality Improvement Team will review the results of the monthly Nursing lab audits and the monthly Pharmacist Audits. This will be an ongoing QA/QI measure.

ON going QA/QI measure