DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495403	A. BUILDING _____ B. WING _____	06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD MANOR	1900 LAUDERDALE DRIVE RICHMOND, VA 23238

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F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 6/27/17 through 6/29/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated. The Life Safety Code survey/report will follow. The census in this 96 certified bed facility was 91 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents 1 through 16) and 3 closed record reviews (Residents 17 through 19).	F 000	The submission of the Plan of Correction does not constitute agreement on the part of Lakewood Manor that the deficiencies cited within the report represent deficient practices on the part of Lakewood. This plan represents our on-going pledge to provide quality care that is rendered in accordance with all regulatory requirements.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] MS, LNHA | TITLE: Administrator | (X6) DATE: 7/14/17

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

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F 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed for 1 resident (Resident #11) of 19 residents in the survey sample to complete an accurate Minimum Data Set assessment. For Resident #11, section J1800 (falls since last assessment) was not coded correctly. The finding included: Resident #11, a 91 year old, was admitted to the facility on 12/13/16. Her diagnoses included Alzheimer's disease, depression, hypertension and reflux. Resident #11's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date of 6/8/17. She was coded with a Brief Interview of Mental Status score of 7 indicating severe cognitive impairment and required extensive assistance with activities of daily living. In section J1800, Resident #11 was coded to have 0 falls since the last assessment (3/13/17).	F 278	F278: Accuracy of assessments: All residents who have sustained falls have the potential to have been miscoded in the MDS section J: 1. A MDS modification was completed and submitted on resident #11 with an ARD date of 6/8/17. 2. A 100% audit of those residents with falls for the months of April, May and June will be completed to ensure the MDS accurately captures each fall. 3. Staff will be educated on the internal tools available to them to track falls to ensure the MDS is coded correctly. 4. DON/designee will conduct a 10% audit of MDS for residents with noted falls for four weeks to ensure coding accuracy has occurred at section J. Results of the audits will be reviewed and reported at the next QAPI meeting for recommendations. Variances will be investigated and staff will be re-educated and/or counseled as indicated. This plan will be effective 8/11/17 and measures will be maintained to ensure ongoing compliance.	

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F 278	Continued From page 2 According to fall investigation documentation provided by the facility, Resident #11 had three falls between 3/13/17 and 6/8/17. The dates of the falls included 6/7/17, 5/19/17, and 3/31/17. On 6/29/17 at 10:50 a.m., an interview was conducted with the nurse who completed the assessment, Registered Nurse A (RN A). When asked about the information she used to complete the fall questions on the MDS, RN A stated she used the nursing notes. It was reviewed with RN A that the 6/8/17 MDS was coded to have 0 falls, but the nursing notes documented that Resident #11 had falls during the assessment period. After RN A had an opportunity to review the clinical record, she stated that she had missed coding the falls when completing the assessment. The Administrator and Director of Nursing were notified of the issue at the end of day meeting on 6/29/17.	F 278		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that	F 309		

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F 309	Continued From page 3 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to, for two Residents (Resident #5 and Resident #13, in a survey sample of 19 residents, to maintain the highest practicable well being. 1. Resident #5 did not receive treatment for constipation. 2. For Resident #13, the facility staff failed to ensure nursing measures such as ice packs, repositioning, massage, and dimmed lights were attempted prior to the administration of pain medications	F 309	F309: Provide care/services for the highest well-being: All residents have the potential to become constipated and to be in pain: 1. Resident #5 and #13 did not sustain any adverse effects from this deficient practice. Both resident's care plans have been updated. Resident #5's care plan now reflects the normal elimination patterns for this individual. Resident #13's care plan now reflects non-pharmacological interventions to be attempted prior to pain medication administration. 2. A 100% audit of the BM Report will be conducted to determine who is flagging and to ensure bowel protocol is being followed appropriately and that care plans reflect individual resident patterns. A 100% audit of PRN pain medication orders will be conducted and a non-pharmacological intervention sheet will be signed off on after three interventions are attempted for each medication request/indication of resident pain.	

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F 309	Continued From page 4 The findings included: Resident #5 was admitted to the facility on 8/19/14. Diagnoses included: Alzheimer's Dementia, high blood pressure, and compression fractures. Resident #5's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5/11/17 was coded as a quarterly assessment. Resident #5 was coded as having a BIMS (brief interview of mental status) of "5" out of a possible 15, or severe cognitive impairment. Resident #5 was also coded as requiring extensive to total assistance of one staff member to perform activities of daily living such as eating and toileting. Review of the nurses notes for Resident #5 revealed the following: on 3/26/17, "No BM (bowel movement) for nine shifts, MOM (milk of magnesia) given. No results as of yet." On 4/8/17, "MOM given no BM for 3 days." On 5/15/17, "No BM for nine shifts, enema given." There were no results documented after the enema was given. Review of the BM record for March, 2017, revealed: From 3/3/17 to 3/9/17 (21 shifts), "No BM" was recorded. MOM was given on 3/7/17. One small BM was recorded on 3/9/17. On 3/10/17 to 3/17/17 (21 shifts), No BM" was recorded. No laxatives or enema was given these dates. On 3/19/17 to 3/23/17 (12 shifts), "No BM" was recorded. MOM was given on 3/26/17. three	F 309	3. Licensed and certified staff will be educated on updated protocol for pain medications and the use of non-pharmacological interventions first. Staff will also be educated to check with continent residents to determine if they had a BM so that it can be charted and possible elimination patterns established for individual residents so this can be care planned. Licensed staff will be educated on the new pain medication administration process which includes non-pharmacological interventions to be attempted first prior to medication administration.	

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F 309	Continued From page 5 large BM's were recorded. Review of the BM record for April, 2017, revealed: On 4/4/17, "NO BM" was recorded from 4/4/17 to 4/8/17 (11 shifts). MOM was given on 4/8/17. Three large BM's were recorded on 4/8/17. On 4/21/17 to 4/26/17 (17 shifts), "No BM" was recorded 5/9/17 to 5/16/17. No MOM was recorded as given, The resident had two medium BM's on 4/26/17. Review of the BM record for May, 2017 revealed: from 5/1/17 to 5/6/17 (18 shifts, "No BM" was recorded. No laxative or enema was recorded as given. The resident had three large BM's on 5/7/17. On 5/9/17 to 5/16/17 (22 shifts) "No BM" was recorded. MOM was given on 5/13/17 and 5/15/17 with no results recorded. A fleets enema was given on 5/15/17. Four extra large BM's were recorded for 5/16/17. On 5/17/to 5/21/17 (13 shifts) "No BM" was recorded. No laxatives or enema was recorded as given. The resident had one small BM on 5/21/17. There were no incidences of vomiting. There were no medications that contributed to constipation. Review of the care plan revealed "history of constipation related to lack of mobility, muscle weakness." Interventions included: "If no BM on day three- report to charge nurse immediately. Charge nurse to monitor ADL report for daily BM's."	F 309	4. DON/designee will conduct an audit of the "BM Report" to determine which residents are flagging for possible elimination issues. Bowl protocol and other interventions will be initiated as indicated. The audit will be done on 20% of residents who flag on the "BM Report" for two weeks and then a 10% audit for those residents who flag on the "BM Report" for two additional weeks. 100% of those residents received PRN pain medication will be audited weekly for four weeks to determine staff compliance with utilization of non-pharmacological interventions prior to administering medications. The supervisor will conduct random audits on both areas moving forward. Results of the audits will be reviewed and reported at the next QAPI meeting for recommendations. Variances will be investigated and staff will be re-educated and/or counseled as indicated. This plan will be effective 8/11/17 and measures will be maintained to ensure ongoing compliance.	

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F 309	Continued From page 6 Review of the policy, "Constipation Prevention Program" revealed, "Supervisor or designee will run a report from (name of software system) that will identify any resident who has not had one BM in the last three days.. The 3-11 charge nurse initiates the dietary interventions and/or standing orders for constipation." On 6/29/17 at 10:05 AM, LPN (licensed practical nurse) A stated, "Every morning we print this out (showed report) and treat accordingly. " She went on to state that if there are no orders for treatment, we use the standing orders." On 6/29/17 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings. 2. For Resident #13, the facility staff failed to ensure nursing measures such as ice packs, repositioning, massage, and dimmed lights were attempted prior to the administration of pain medications. The findings included: Resident #13 was admitted to the facility on 12/16/15. Diagnoses for Resident #13 included but are not limited to Central Pain Syndrome*, Bipolar Disorder*, and Anxiety. Resident #13's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 4/27/17 coded Resident #13 with a BIMS (Brief Interview for Mental Status) score of 15 of 15 indicating no cognitive impairment. In addition, the Quarterly MDS scored Resident #13 as being independent in Bed Mobility and Transfers. The Quarterly	F 309		

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F 309	Continued From page 7 MDS scored Resident #13 as having received scheduled and as needed pain medications. The Quarterly MDS scored Resident #13 as not having had non-medication interventions. Resident #13's 6/19/17 Care Plan documented a Focus Area of Comfort/Pain. Interventions included but are not limited to the following: Utilize pain scale to assess intensity of pain (faces or 0-10 scale). Encourage the same type of scale with each assessment to compare consistent values. Attempt to reposition, use pillow props. Protect painful areas with positioning. Ice packs to low back prn (as needed). Provide for rest periods. Medications adjusted per MD (Medical Doctor) orders A Random review of Resident #13's April Medication Administration Record (MAR) was completed. Pain medications prescribed in April 2017 for Resident #13 included: Physician ordered 5/16/16 Hydromorphone 1 mg (milligram)/ml (milliliter) oral liquid. Give 1 ml PO (By Mouth) every 4 hours PRN (as needed) for pain. Physician ordered 4/24/16 Tylenol 325 mg tablet two tablets (650 mg) PO Q6H as needed headache Resident #13 received as needed Hydromorphone as noted above in physician orders on the following dates: 4/10/17 through 4/18/17. Review of Nursing Progress notes through 4/10/17 through 4/18/17 documented no non-pharmacological measures administered for	F 309		

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F 309	Continued From page 8 the following dates prior to the administration of hydromorphone: Pain scale documented through these dates ranged from 7-10. The Director of Nurses (DON) stated on 6/20/17 at approximately 9:50 a.m. that non-pharmacological measures was something new for us. She stated the facility spoke with Corporate advisors yesterday and were told to currently utilize the Care Plan for Non-pharmacological Measures. The Director of Nurses (DON) was asked on 6/29/17 at approximately 11:55 a.m., if she could provide any proof that non-pharmacological measures were offered for the dates: 4/10/17 through 4/18/17. The DON stated, "No." The Facility Administrator on 6/29/17 at approximately 12:03 p.m., wanted to discuss Federal Regulations regarding Pain's wording. The Administrator stated the Regulations stated "may" utilize non-pharmacological measures while comparing non-pharmacological measures to antiphychotic medication regulation that the Administrator stated read, "must use" non pharmacological measures. The Administrator was informed that Guidance during FOSS (Federal Oversight Survey Support) Surveyors have been advised to observe for non-pharmacological measures prior to both as needed analgesics and anitphychotics. The Facility Policy revised 11/16, titled "Pain Management" documented the following: (Facility name) will ensure that pain management is provided to residents who require such	F 309		

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F 309	Continued From page 9 services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Pain management will be a collaborative effort between the resident, physician, and representatives of the interdisciplinary team including but not limited to: pharmacy, nursing, mental health professionals, rehab therapy, social services, activities, etc. Non-pharmacological interventions may be appropriate along or in conjunction with medications. Some non-pharmacological interventions include: Environmental - adjusting the room temperature, smoothing the linens, providing a pressure reducing mattress, repositioning, etc; Physical - ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation, massage, accupuncture,etc; Cognitive or Behavioral - relaxation, music, diversions, activities, etc. The Facility Pain Management Policy documented: Pain management in older adults. In: Evidence-based geriatric nursing protocols for best practice; Agency for Healthcare Research and Quality, revised 2012 https://www.guideline.gov/summaries/summary/43932 documented the following from the website. Nonpharmacological (Pasero & McCaffery, 2011 [Level VI]; Wells, Pasero, & McCaffery, 2008 [Level I]) Investigate older patients' attitudes and beliefs about, preference for, and experience with nonpharmacological pain treatment strategies. Tailor nonpharmacological techniques to the individual.	F 309		

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F 309	Continued From page 10 Cognitive behavioral strategies focus on changing the person's perception of pain (e.g., relaxation therapy, education, distraction) and may not be appropriate for cognitively impaired persons. Physical pain relief strategies focus on promoting comfort and altering physiologic responses to pain (e.g., heat, cold, transcutaneous electrical nerve stimulation [TENS] units) and are generally safe and effective. Older adults are at increased risk for adverse drug reactions due to age- and disease-related changes in pharmacokinetics and pharmacodynamics. Monitor medication effects closely to avoid overmedication or undermedication and to detect adverse effects. Assess hepatic and renal functioning. Choose the correct type of analgesic. Use opioids for treating moderate-to-severe pain and nonopioids for mild-to-moderate pain. Select the analgesic based on thorough medical history, comorbidities, other medications, and history of drug reactions. Among nonopioid medications, acetaminophen is the preferred drug for treating mild-to-moderate pain. Guidelines recommend not exceeding 4 g/day (maximum 3 g/day in frail elders). The maximum dose should be reduced to 50% to 75% in adults with reduced hepatic function or history of alcohol abuse. Pain Prevention Develop a written pain treatment plan upon admission to the hospital, or prior to surgery or treatments. Help the patient to set realistic pain treatment goals, and document the goals and plan. Assess pain regularly and frequently to facilitate	F 309		

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F 309	Continued From page 11	F 309		

appropriate treatment.
Anticipate and aggressively treat for pain before, during, and after painful diagnostic and/or therapeutic treatments. Administer analgesics 30 minutes prior to activities.
Educate patients, families, and other clinicians to use analgesic medications prophylactically prior to and after painful procedures.
Educate patients and families about pain medications and their side effects; adverse effects; and issues of addiction, dependence, and tolerance.
Educate patients to take medications for pain on a regular basis and to avoid allowing pain to escalate.
Educate patients, families, and other clinicians to use nonpharmacological strategies to manage pain, such as relaxation, massage, and the use of heat and cold.

The facility administration was informed of the findings during a briefing on 6/29/17 at approximately 12:15 p.m. The facility did not present any further information about the findings.

Definitions

Central Pain Syndrome: National Institute of Health documents: Central pain syndrome is a neurological condition caused by damage to or dysfunction of the central nervous system (CNS), which includes the brain, brainstem, and spinal cord. This syndrome can be caused by stroke, multiple sclerosis, tumors, epilepsy, brain or spinal cord trauma, or Parkinson's disease. The character of the pain associated with this syndrome differs widely among individuals partly

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F 309	Continued From page 12 because of the variety of potential causes. Central pain syndrome may affect a large portion of the body or may be more restricted to specific areas, such as hands or feet. The extent of pain is usually related to the cause of the CNS injury or damage. Pain is typically constant, may be moderate to severe in intensity, and is often made worse by touch, movement, emotions, and temperature changes, usually cold Bipolar Disorder: Medlineplus documents: Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression Hydromorphone: Medlineplus documents: Hydromorphone is used to relieve pain. Hydromorphone extended-release tablets are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. Hydromorphone extended-release tablets should only be used to treat people who are tolerant (used to the effects of the medication) to opioid medications because they have taken this type of medication for at least one week and should not be used to treat mild or moderate pain, short-term pain, pain after an operation or medical or dental procedure, or pain that can be controlled by medication that is taken as needed. Hydromorphone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. Side effects may include:	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495403	A. BUILDING _____ B. WING _____	06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD MANOR	1900 LAUDERDALE DRIVE RICHMOND, VA 23238

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F 309	Continued From page 13 headache difficulty falling asleep or staying asleep dry mouth lightheadedness drowsiness heavy sweating muscle, back or joint pain stomach pain anxiety flushing itching depression section, call your doctor immediately or get emergency medical treatment: rash hives swelling of the eyes, face, lips, tongue, mouth, throat, arms, hands, feet, ankles, or lower legs difficulty breathing or swallowing hoarseness agitation, hallucinations (seeing things or hearing voices that do not exist), fever, sweating, confusion, fast heartbeat, shivering, severe muscle stiffness or twitching, loss of coordination, nausea, vomiting, or diarrhea nausea, vomiting, loss of appetite, weakness, or dizziness inability to get or keep an erection irregular menstruation decreased sexual desire seizures chest pain extreme drowsiness fainting lightheadedness when changing positions Hydromorphone may cause other side effects. Call your doctor if you have any unusual	F 309		

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 309	Continued From page 14 problems while you are taking this medication. If you experience a serious side effect, you or your doctor may send a report to the Food and Drug Administration's (FDA) MedWatch Adverse Event Reporting Tylenol: Medlineplus documents: Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. Side effects: may include red, peeling or blistering skin rash hives itching swelling of the face, throat, tongue, lips, eyes, hands, feet, ankles, or lower legs hoarseness difficulty breathing or swallowing	F 309		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 325		