THE LAURELS
OF UNIVERSITY PARK
A Skilled Nursing and Rehabilitation Center

May 25, 2016

Ms. Wietske G. Weigel-Delano

LTC Supervisor

OLC, Division of Long Term Care Services

9960 Mayland Drive

Suite 401

Richmond, VA 23233

Ms. Delano,

Please find enclosed our Plan of Correction for Survey ending April 21, 2016 with corrections made to F250, F314, and F282. Our alleged date of compliance is May 26, 2016

Should you have any questions, please feel free to contact me.

Thank You,

Kelly Carter

Administrator

Enclosure:

2567

2420 Pemberton Road • Richmond, VA 23233

www.laurelsofuniversitypark.com

804.747.9200 • FAX 804.747.1574

COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

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

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

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

May 5, 2016

Ms. Kelly Carter, Administrator
The Laurels Of University Park
2420 Pemberton Rd
Richmond, VA 23233

RE: The Laurels Of University Park
Provider Number 495109

Dear Ms. Carter:

An unannounced standard survey, ending April 21, 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. Three complaints were investigated during the survey. Two complaints were substantiated, with deficiencies. One complaint was unsubstantiated, with no deficiencies.

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.state.va.us/OLC/longtermcare/". 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, LTC Supervisor
Division of Long Term Care

Enclosure

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

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495109	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/21/2016
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 153	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, Resident interview, facility document review, and in the course of a compliant investigation, it was determined that the facility staff failed to provide copies of the clinical record to the Resident in a timely manner for one of 29 residents in the survey sample, Resident # 13. A request was made by the Resident for a copy of his medical record on 3/21/16. Resident # 13 documented that as of 3/28/16 he had not received a copy of his record (approximately five days after the request excluding holidays and weekends). The findings include: Resident # 13 was admitted to the facility on 7/20/15 with diagnoses including, but not limited to: neurogenic bladder, hyperlipidemia, paraplegia, atrial fibrillation, and high blood pressure. On the most recent complete MDS (minimum data assessment), a quarterly assessment with ARD (assessment reference date) 12/31/15, Resident # 13 was coded on the resident's BIMS (brief interview for metal status) as 15 out of 15, indicating Resident #13's cognition was intact. During an interview on 4/19/16 at 4:10 p.m. and again on 4/20/16 at 3:00 p.m. with Resident # 13 the request for medical records was discussed. Resident # 13 stated that he was trying to get approved for an apartment and had just received a call from the apartments. These interviews corroborated the information in the hand written complaint. Documentation in the hand written complaint form, dated 3/28/16, revealed the following: "On 3-21-2016 I received a call from (name of apartments) indicating to me that an apartment was available and I could move in on 5/2/16. I inForm (sic) the Facilities administrator about the apartment and told her I would need my medical records information to give to my independent living advisor (name of advisor). A meeting has been scheduled For (sic) 4-6-2016 at 11:00 a.m. For myself, my ombudsman, (name of advisor), and nursing staff but I have not received any documents." During an interview on 4/20/16 at 3:00 p.m. with Resident # 13 he stated, "I got the call from the apartments on 3/21/16 and that same day I went to the administrator and requested my records. An appointment was setup for 4/6/16 and I Wanted to have everything ready. I got the records about a week after I requested them."

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 153	Continued From Page 1 During an interview on 4/20/16 at 10:40 a.m. with ASM # 1, the administrator, this concern was discussed. ASM # 1 did remember that records were requested. At this time a request was made for any documentation concerning Resident # 13's request for medical records. On 4/20/16 at 4:33 p.m. an attempt to reach the ombudsman was made and a message was left. No return call was received during the survey. During the end of day interview on 4/20/16 at approximately 6:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM # 3, the regional Quality Assurance Manager, and ASM # 4, the Regional Manager, were informed of this concern. At this time a request was made for any additional information and also a copy of Resident # 13's admission agreement and the facility policy for medical records requests. An interview on 4/21/16 at 7:40 a.m. with ASM # 1 revealed the following: "I could find no documentation as to when (name of resident) asked for or received copies of his record ---he did get them, just not sure when." ASM # 1 did not identify the staff responsible to make the copies of the records. During an interview on 4/21/16 at 9:00 a.m. with OSM (other staff member) # 2, the social worker, the process for obtaining medical records was discussed. OSM # 2 stated that she would direct those requesting records to make a request at the front desk and then the request goes to medical records. Review of the Facility Policy: "GUEST/GUARDIAN ACCESS TO RECORDS" documents: "POLICY: As the information contained within the clinical record is the property of the guest, and it is his/her legal right to gain access to this information, a record may be reviewed by the guest or by an individual granted access to such by the guest. Per regulation, the guest has the right to inspect and purchase photocopies of all records pertaining to him/her upon request. PROCEDURE: 1. Refer all guests or authorized individuals who request to review their records to the Administrator. A. The request may be oral or written..." No further information was provided prior to exit. COMPLAINT DEFICIENCY

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	C 04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(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 04/19/2016 through 04/21/2016. 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 145 certified bed facility was 141 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 21) and 8 closed record reviews (Residents 22 through 29).	F 000	The Laurels of University Park wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is May 26, 2016. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: LNHA | (X6) DATE: 5/25/16

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 156	Continued From page 1	F 156		

the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and

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F 156	Continued From page 2	F 156		

misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and closed clinical record review, the facility staff failed to provide written notification of discontinuation of services (Generic Notice) and the right to appeal this decision prior to discharge home from the facility for one of three closed records reviewed for this notice, Resident # 24.

The facility failed to provide notice of discontinuation of services via the Notice of Provider Non-coverage also known as the "Generic Notice" form to Resident # 24 prior to her discharge to home on 2/11/16. Resident # 24 had 64 days of Skilled Nursing coverage available at the time of discharge.

The findings include:

F Tag 156

Resident #24 was discharged from the facility on 2/11/16.

All current residents have the potential to be affected.

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F 156	Continued From page 3 Resident # 24 was admitted to the facility on 1/6/16 with diagnoses including, but not limited to: high blood pressure, anemia, chronic kidney disease stage III, and coronary artery disease. The most recent MDS (Minimum Data Set) assessment, was a 14-day assessment with an assessment reference date (ARD) of 1/20/16, coded Resident # 24 as being cognitively intact scoring a 15 out of 15 on the BIMS (Brief Interview for Mental Status). Resident # 24 was coded as always being understood by others and as always understanding others for communication. A review of the clinical record for Resident # 24 revealed that he was discharged to his home on 2/11/16. A copy of the Generic Notice form was requested from the administrative team on 4/20/16/16 at 12:40 p.m. During an interview on 4/20/16 at approximately 3:00 p.m. with ASM (administrative staff member) # 1, ASM # 1 reported that there was no Generic Notice available for Resident # 24. During the end of day interview on 4/20/16 at approximately 6:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM # 3, the regional Quality Assurance Manager, and ASM # 4, the Regional Manager, were informed of this concern. During an interview on 4/21/16 at approximately 8:10 a.m. with ASM # 1, a request for the facility policy was made. During an interview on 4/21/16 at 8:35 a.m. with OSM (other staff member) # 2, the social worker,	F 156	The NHA will in-service business, admission staff, and social services staff on resident rights to include notice of discontinuation of services via the Notice of Provider Non-coverage also know as the Generic Notice form prior to discharge to home. Social Services will provide the Notice of Provider Non-coverage to all residents receiving skilled nursing services according to regulations. The NHA or designee will audit applicable discharges weekly for 4 weeks and report results to the NHA. Any variances will be corrected and continuing education will be provided. The Regional Business Office manager will review discharges randomly thereafter to assure the process remains in place and will report and variances to the NHA.	

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F 156	Continued From page 4 the process to issue a Generic Notice (referred to by the social worker as a "cut letter"). OSM # 2 stated she usually gives the form to resident (guest) or the guest's family to sign, then the form is given to the business office. She finds out who is going home at the ITM (interdisciplinary team meeting) and then gets the form signed. She was not the social worker assigned to this resident so she doesn't know what happened. During an interview on 4/21/16 at 9:30 a.m. with ASM # 1, the administrator, ASM #1 stated that the facility has no policy but does follow the regulations and presented a copy of the instructions on issuing a notice. These instructions documented: "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123." "When to Deliver the NOMNC: A Medicare provider or health plan (Medicare Advantage plans and cost plans collectively referred to as "plans") must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services." "The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily ..." No further information was provided prior to exit.	F 156	Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250		

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F 250	Continued From page 5 The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide medically-related social services to attain or maintain the highest practicable physical, well-being for two of 29 residents in the survey sample, Resident #12 and 6. 1. The facility staff failed to provide/obtain timely dental services for Resident #12. 2. The facility staff failed to provide/obtain timely dental services to Resident #6. The findings include: 1. Resident #12 was admitted to the facility on 12/14/13 with diagnoses that included, but were not limited to, CVA (cerebral vascular accident - a stroke), HTN (hypertension - high blood pressure), hyperlipidemia (elevated lipids in the blood stream), hemiplegia, depression, and hypercholesteremia. Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/2/16. Resident #12 was coded on the MDS as having a BIMs	F 250	F Tag 250 Resident #12 complained of tooth pain during the survey. Resident #12 had received dental services prior and an appointment was made following the survey. However, resident refused and stated his pain was resolved. Resident will receive services in the future as needed. Resident #6 had dental services prior to survey and will be offered services as needed in the future. All residents needing dental services have the potential to be affected by this practice. An audit will be completed on all residents to identify if they have a need for dental services that have not been addressed.	

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THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

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F 250	Continued From page 6 (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. Resident #12's record documented the resident was under Medicaid services. A review of Resident #12's clinical record revealed, in part, the following physician notes: "12/2/15. Pt. (patient) requests visit today r/t (related to) right tooth "ache" x 2 days. Assessment and Plan: cracked tooth, acute. Nursing to schedule Dentist appointment." "1/18//16. Interval history: Reports mouth toothache pain. Nurse spoke to pt's (patient's) son regarding dental appt (appointment). Awaiting son to make dental appt. Assessment and plan: Toothache R (right) anterior- ongoing- Staff to schedule dental appointment asap (as soon as possible) after checking with family re: preferred provider." Further review of Resident #12's clinical record did not reveal any nursing notes or social service notes that evidenced that Resident #12 had received dental services. A review of nursing notes for Resident #12 revealed, in part, that Resident #12 had received pain medication for documented toothache on the following dates: 12/10/15; 12/16/15; 12/26/15; 1/25/16; 3/21/16; 3/23/16; 3/24/16; 3/25/16; 3/26/16; 3/27/16; 4/18/16 and 4/19/16. On 4/20/16 at 10:00 a.m. an interview was conducted with Resident #12. Resident #12 was asked whether or not he had seen a dentist. Resident #12 stated that he had seen one on	F 250	Any identified residents will receive dental services as indicated. The NHA will in service social services staff on providing medically – related services to attain or maintain the highest practicable physical, well- being. The Social Services Director will audit residents with need for services weekly for 4 weeks to ensure timely appointments are made to maintain well- being. Results will be reported to the NHA. Any variances will be corrected and continued education provided. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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2/10/16 because of toothache. Resident #12 was asked whether or not he continued to have problems with the tooth. Resident #12 stated that he was supposed to go back and have the tooth surgically extracted. Resident #12 stated that the tooth had broken and the dentist couldn't just pull the tooth. Resident #12 was asked whether or not he continued to have problems with the tooth. Resident #12 stated that it hadn't bothered him too much.

On 4/20/16 at 11:40 a.m. an interview was conducted with RN (registered nurse) #4, the unit manager. RN #4 was asked whether or not there was a consult request for Resident #12. RN #4 stated that she did not know. RN #4 was asked whether or not Resident #12 had seen a dentist. RN #4 stated that she thought he had seen a dentist. RN #4 was asked when Resident #12 saw a dentist and to provide the documentation of the dental visit. RN #4 was unable to locate any documentation and stated, "If the resident didn't bring anything back from the visit we wouldn't have anything." RN #4 was asked what the responsibility of the nursing staff was to determine the plan of care for a resident who had been on a consult visit. RN #4 stated, "We should have called to follow up." RN #4 requested more time to gather information.

On 4/20/16 at 12:45 p.m. RN #4 stated that she had called the dentist and that he had "no recommendations". RN #4 was asked to provide a consult sheet or note from the dentist that would evidence no further care required. RN #4 stated she did not have it but would try. RN #4 was asked who was responsible for resident care, RN #4 responded; "Nurses on the unit make sure that the medications and treatments are provided

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and that ADL (activities of daily living) are done. Nurses are also responsible to make sure that physician orders are followed and that the resident sees the physician when necessary."

RN #4 was asked what is documented when a resident leaves the facility for a consult. RN #4 responded, "The night shift nurse gets the paperwork ready for the appointment and generally the nurses document when the resident leaves the facility. We did not document anything when (name of Resident #12) when to see the dentist." RN #4 was asked what other documentation would be included when a resident goes out of the facility on an appointment. RN #4 responded, "There should be documentation when they return, we would document the time of return and whether or not there are any new orders." RN #4 was asked whether or not this was done for Resident #12, RN #4 stated it was not done. RN #4 was asked whether or not Resident #12 needed to go back to the dentist, RN #4 responded that she did not know.

On 4/20/16 at 1:00 p.m. an interview was conducted with LPN (licensed practical nurse) #10. LPN #10 stated that she worked with Resident #12 the day following his dental appointment and that he (Resident #12) had told her that he needed an extraction. LPN #10 was asked whether or not she documented anything or followed up with the dentist that Resident #12 had seen. LPN #10 responded that she had talked to his (Resident #12's) son about getting another appointment. LPN #10 was asked whether or not she followed up and she stated that she did not. LPN #10 was asked what she should have done to ensure that Resident #12 received the necessary treatment. LPN #10

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stated that she should have followed up or involved social services to get Resident #12 the treatment he needed.

A review of Resident #12's care plan dated 9/1/15 and reviewed on 3/9/16 revealed, in part, the following documentation: "Onset/DC (discontinued) 12/28/15. Problems/Conclusions: Pain: Actual Pain related to cracked tooth. Approaches/Interventions: Administer medications for pain and observe for effectiveness (sig)/side effects and report ineffectiveness to physician."

At an end of the day meeting on 4/20/16 at 5:50 p.m., ASM (administrative staff member) #1, the facility administrator; ASM #2, the director of nursing; ASM #3, the regional QA (quality assurance manager) and ASM #4, the regional manager; were made aware of the above findings. ASM #1 stated that she would look for information to determine whether or not anything was documented about Resident #12's dental appointment. A policy was requested at this time for consult appointments.

On 4/20/16 at 8:40 a.m. ASM #1 was interviewed. ASM #1 stated, "We are still trying to get documentation on the dental appointment. We know that nothing is documented and we know that follow up was not done."

On 4/21/16 at 9:05 a.m. an interview was conducted with OSM (other staff member) #2, the social worker. OSM #2 was asked what her role was in regards to dental appointments. OSM #2 responded that she did not get involved with dental appointments unless there was a problem. OSM #2 was asked about Resident #2. OSM #2

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responded, "I had no idea about his dental issues. He never mentioned dental issues to me."

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

2. The facility staff failed to provide/obtain timely dental services for Resident #6.

Resident #6 was admitted to the facility on 5/7/11 with diagnoses including, but not limited to: Bipolar disorder, seizure disorder, Schizophrenia, dementia, heart disease, and depression. On the most recent MDS (minimum data set), a significant change assessment with ARD (assessment reference date) 2/10/16, she was coded as having moderate cognitive impairment for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was coded as having broken teeth.

On 4/20/16 at 8:10 a.m., Resident #6 was observed sitting up in bed in her room. When the resident smiled, the surveyor observed that she had multiple chipped/broken/missing teeth. An attempt to interview the resident about her dental status was unsuccessful due to Resident #6's nonsensical responses.

A review of Resident #6's clinical record revealed a nurse's note written 11/12/15 by LPN (licensed practical nurse) #1. The note stated, in part: "Guest commented that she eats all of her food but that she only has one tooth. RD (registered dietician) made aware and diet downgraded to mechanical soft."

Further review revealed the following note written

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by OSM (other staff member) #1, the registered dietician, on 12/2/15: "Diet has been liberalized from Heart Healthy and texture has been changed to mechanical soft due to poor dentition."

Further review revealed the following note written by the nurse practitioner on 12/11/15: "[Resident #6] states difficulty chewing, no difficulty swallowing. Ordered dental consult." The record review revealed no evidence that the nurse practitioner actually ordered the consult, and attempts to interview the nurse practitioner during the survey were unsuccessful.

Further review revealed the following note written on 2/9/16 by OSM #2, the social worker: "Guest (sic) family is looking to have residents (sic) teeth looked at. Guest has Medicaid and I provided a number to the unit manager for [name of local dentist] to call and make an appointment."

A review of Resident #6's weights revealed, in part, the following: 11/5/15 - 157.4; 12/1/15 - 156.4; 1/4/16 - 155.8; 2/7/16 - 143; 3/1/16 - 146.8; 4/4/16 - 147. The review revealed multiple interventions by the facility staff to address Resident #6's weight loss, including double portions of meals and dietary supplements.

A review of the clinical record revealed the following note written by the nurse practitioner on 3/18/16: "Weight loss over several months due to self-restricting diet to fruit and cottage cheese due to dental issues. Brother took her to DDS (dentist) 3/16/16 and she had #7 and #26 extracted."

A review of the comprehensive care plan for

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Resident #6 dated 2/22/16 revealed, in part, the following: "Alteration in dental status related to: some of natural teeth missing, broken/loose/carious teeth....Dental consults as needed."

On 4/20/16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional quality assurance manager, and ASM #4, the regional manager, were informed of these concerns.

On 4/21/16 at 8:35 a.m., OSM #2 was interviewed regarding the process for obtaining dental consults for residents. She stated: "I don't really get involved in that. If someone needs a phone number or something, I will get them the number. The nurses do the calling and set the appointments." When shown the above referenced note (2/9/16) and asked what she remembered about Resident #6's dental situation, she stated: "The guest's son contacted me to let me know." She stated that she thought it was the son's job to make the appointment for the resident. She stated: "I gave the son the number." When asked if she followed up to see if the son made the appointment in a timely manner, she stated, "No I didn't. I assumed he would make the call. I gave him the number of a dentist who takes Medicaid and that's the last I heard of it." When asked if she was aware that Resident #6 had been losing weight since November 2015, she stated: "Sometimes I went to the care plan meetings. But now I don't much anymore." She stated she did not have a memory of the weight loss coming up in any discussions with other staff members. When asked to review her note again and to explain the discrepancy between what she had just told the

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surveyor (that she gave the resident's son the phone number) and what her note stated (that she gave the phone number to the unit manager [LPN #1], she stated: "Oh. Well, maybe it was the unit manager who asked for the number. I'm assuming that I talked to the unit manager, not the son." When asked if she specifically remembered a conversation with the resident's son about the resident's dental needs, she stated: "Now that you mention it, not really. [LPN #1] probably brought it up in an evening meeting."

On 4/21/16 at 8:45 a.m., LPN #1 was interviewed regarding the process for obtaining dental services for residents. She stated: "We don't have a dentist who comes here." She stated that she becomes aware of needs for dental services from residents themselves or from families. She stated: "Most of our residents are on Medicaid. The nurses are responsible for calling the dentists and setting up transportation." When shown the progress note from the nurse practitioner dated 12/11/15, she stated: "This is the first time I'm seeing this. It's just a note. I don't see an order." When asked what she remembered about Resident #6's dental consult resulting in tooth extraction on 3/16/16, she stated: "I can't tell you. We don't keep the paperwork. I don't know when the appointment was actually made." She stated she would "do some checking" and let the surveyor know what she found out. On 4/21/16 at 11:05 a.m., she stated: "I don't have any notes or any information. I don't know why it took so long for us to get her a dental consult."

On 4/21/16 at 11:10 a.m., OSM #1 was interviewed regarding Resident #6's dental status. She stated: "We have been following [the

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F 250	Continued From page 14 resident] for some time." She stated she did not recall anyone telling her that the resident was having trouble chewing due to poor dentition. She stated that she had not actually assessed the resident face-to-face. When asked about the physician's comment about the resident self-restricting her diet due to dental issues, she stated: "I was not thinking this was related to her dentition. I thought she just preferred those foods for some reason." A review of the facility policy entitled "Dental Services" revealed, in part, the following: "The facility will provide or obtain from an outside resource, routine and twenty-four (24) hour emergency dental services to meet the needs of each guest...If necessary, the facility must assist the guest in making appointments, arranging transportation to and from the dentist's office, and promptly referring guests with lost or damaged dentures to a dentist." No further information was provided prior to exit.	F 250		
F 278 SS=E	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	F 278		

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F 278	Continued From page 15 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 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 observation, staff interview, clinical record review and facility document review, it was determined that facility staff failed to complete an accurate MDS (Minimum Data Set) assessment for five of 29 residents in the survey sample; Residents #4, #9, #2, #13, and #22. 1. The facility staff failed to properly code section O0250 (Influenza Vaccine) of a significant change MDS assessment with an ARD (Assessment Reference Date) of 3/5/16 for Resident #4. 2a. The facility staff failed to properly code section O0250 (Influenza Vaccine) of a quarterly MDS assessment with an ARD of 3/21/16 for Resident #9. b. The facility staff failed to properly code section "C (cognitive patterns), D (Mood) and E (Behavior)" of a quarterly MDS assessment with an ARD of 3/21/16 for Resident #9. 3. The facility staff failed to assess and accurately code Resident #2's dental status on the resident's	F 278	F Tag 278 Resident # 4 no longer resides at the facility. Resident #9 MDS has been opened and will be completed and submitted by date of completion. Resident #2 MDS has been opened and will be completed and submitted by date of completion. Resident #13 MDS has been opened and will be completed and submitted by date of completion. Resident #22 no longer resides at the facility.	

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F 278	Continued From page 16 significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/29/16. 4. The facility staff failed to ensure Resident #13's quarterly MDS assessment with an ARD (assessment reference date) of 3/18/16 was correctly coded for cognition (Section C) and mood (Section D). 5. The facility staff failed to correctly code that Resident #22 was receiving oxygen therapy on the five day admission MDS (minimum data set) assessment dated 7/28/15. The findings include: 1. The facility staff failed to properly code section O0250 (Influenza Vaccine) of a significant change MDS assessment with an ARD (Assessment Reference Date) of 3/5/16 for Resident #4. Resident #4 was admitted to the facility on 12/6/13 with diagnoses that included but were not limited to high blood pressure, arthritis, stroke, anxiety, dementia, depression, and diabetes. Resident #4's most recent MDS (minimum data set) was a quarterly review assessment with an ARD (assessment reference date) of 3/5/16. The resident was coded as being cognitively impaired in the ability to make daily life decisions, scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status). The resident was coded as requiring total dependence from staff with most ADLS (activities of daily living). Review of Resident #4's most recent comprehensive MDS (Minimum Data Set) was a significant change assessment with an ARD of 3/5/16. Section O0250 (Influenza Vaccine) of the MDS assessment documented the following: "A. Did the resident receive the influenza vaccine in the facility for this year's influenza season?	F 278	All residents with MDS assessment submissions have the potential to be affected. An audit of the last 30 days of MDS assessments will be completed for accurate coding for influenza vaccine, dental status, oxygen therapy and dashes for sections C, D, E, \and Q. Any corrections or updates needed will be made and submitted. All future MDS assessments will be reviewed accordingly to the MDS schedule or as a change in status indicates. Regional clinical resource specialist will educate MDS department and social services department on appropriate coding and exceptions for using dashes on the MDS. MDS coordinator will audit completed MDS assessments for 4 weeks and any identified issues will be corrected and submitted.	

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F 278	Continued From page 17 0. No--> (arrow) Skip to O0250C, If influenza vaccine not received state reason 1. Yes --> (arrow) Continue to O0250B, Date influenza vaccine received." A "0" was documented under Part A indicating that the influenza vaccine was not administered. "C. If influenza vaccine not received, state reason: 1. Resident not in this facility during this year's influenza vaccination season. 2. Received outside of the facility. 3. Not eligible. 4. Offered and declined. 5. Not offered. 6. Inability to obtain influenza vaccine due to a declared shortage. 9. None of the above. A "-" (dash) was documented under part B of section O0250 indicating that this area was not assessed. Further review of the clinical record revealed that Resident #4's RP (responsible party) had declined receiving the flu vaccination annually. Her signature was dated "12/6/13." On 4/20/16 at 5:10 p.m., an interview was conducted with RN (Registered Nurse) #3, the MDS coordinator. When asked what dashes meant on the MDS assessment she stated, "I am not sure, dashes are not even an option. This means it was not assessed." RN #3 confirmed that section O0250B was not assessed for Resident #4. She stated that she uses the RAI (Resident Assessment Instrument) manual when completing the MDS. On 4/20/16 at 6:04 p.m., administration was made aware of the above concerns. No further information was presented prior to exit. The MDS RAI (Resident Assessment Instrument Manual) documents the following:	F 278	Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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"Coding Instructions for O0250A, Did the Resident Receive the Influenza Vaccine in This Facility for This Year's Influenza Season?
Code 0, no: if the resident did NOT receive the influenza vaccine in this facility during this year's Influenza season. Proceed to If Influenza vaccine not received, state reason (O0250C).
Code 1, yes: if the resident did receive the influenza vaccine in this facility during this year's Influenza season. Continue to Date Vaccine Received (O0250B).

Coding Instructions for O0250C, If Influenza Vaccine Not Received, State Reason
If the resident has not received the influenza vaccine in this facility for this year's Influenza season (i.e., 0250A=0), code the reason from the following list:
Code 1, resident not in facility during this year's influenza season: Resident not in the facility during this year's Influenza season.
Code 2, received outside of this facility: includes influenza vaccinations administered in any other setting (e.g., physician office, health fair, grocery store, hospital, fire station) during this year's Influenza season.
Code 3, not eligible-medical contraindication: if vaccination not received due to medical contraindications, including allergic reaction to eggs or other vaccine component(s), a physician order not to immunize, or an acute febrile illness is present. However, the resident should be vaccinated if contraindications end.
Code 4, offered and declined: resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the vaccine.
Code 5, not offered: resident or responsible party/legal guardian not offered the vaccine.

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Code 6, inability to obtain vaccine due to a declared shortage: vaccine unavailable at the facility due to declared vaccine shortage. However, the resident should be vaccinated once the facility receives the vaccine. The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year.
Code 9, none of the above: if none of the listed reasons describe why the vaccination was not administered. This code is also used if the answer is unknown."

2a. The facility staff failed to properly code section O0250 (Influenza Vaccine) of a quarterly MDS assessment with an ARD of 3/21/16 for Resident #9.

Resident #9 was admitted to the facility on 11/21/14 with diagnoses that included but were not limited to neurosyphilis,* major depressive disorder, altered mental status, chronic pain, and dementia.

Resident #9's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/21/16.
Resident #9 was coded as being able to understand others for communication and being understood by others for communication.
Resident #9 was coded as requiring supervision with transfers, dressing, locomotion, and ambulation; extensive assistance from staff with toileting, personal hygiene and bathing; and independent with meals.

Resident #9's most recent MDS (Minimum Data Set) assessment was a quarterly assessment

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with an ARD of 3/21/16. Section O0250 (Influenza Vaccine) of the MDS documented the following:
"A. Did the resident receive the influenza vaccine in the facility for this year's influenza season?
0. No --> (arrow) Skip to O0250C, If influenza vaccine not received, state reason
1. Yes --> (arrow) Continue to O0250B, Date influenza vaccine received."
A "0" was documented under Part A indicating that the influenza vaccine was not administered.
"C. If influenza vaccine not received, state reason:
1. Resident not in this facility during this year's influenza vaccination season.
2. Received outside of the facility.
3. Not eligible.
4. Offered and declined.
5. Not offered.
6. Inability to obtain influenza vaccine due to a declared shortage.
9. None of the above.
A "-" (dash) was documented under part B of section O0250 indicating that this area was not assessed.
Further review of the clinical record revealed that Resident #9's RP (responsible party) had consented to receive the flu vaccination annually. Her signature was dated "1/26/14."
On 4/20/16 at 5:10 p.m., an interview was conducted with RN #3, the MDS coordinator. She confirmed that Resident #9's MDS was coded improperly. She stated that dashes on the MDS meant an assessment was not attempted or completed. She stated that her department was responsible for completing section O. She did not have a reason why this section was not completed.
On 4/20/16 at 6:04 p.m., administration was made aware if the above concerns. No further

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information was presented prior to exit.
*Neurosyphlis- is a bacterial infection of the brain or spinal cord. It usually occurs in people who have had untreated syphilis for many years. This information was obtained from https://www.nlm.nih.gov/medlineplus/ency/article/000703.htm.

b. The facility staff failed to properly code section "C (cognitive patterns), D (Mood) and E (Behavior)" of a quarterly MDS assessment with an ARD of 3/21/16 for Resident #9.

Resident #9's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD of 3/21/16. Resident #9 was coded as a "1" under section B0700 "Usually Understood" by others for communication. Resident #9 was also coded "1" under section B0800 "Usually Understands" others for communication. Resident #9 was coded as requiring supervision with transfers, dressing, locomotion, and ambulation; extensive assistance from staff with toileting, personal hygiene and bathing; and independent with meals.

Section C0100 (Cognitive Patterns) of the MDS dated 3/21/16 documented the following: "Should Brief Interview for Mental Status (C0200-C0500) be Conducted? - Attempt to conduct interview with all residents"

Dashes "-" were coded for sections C0100, C0200, C0300, C0400 and C0500 indicating that this assessment was not completed. Section C0600 through C1000, were also coded with dashes indicating that the staff assessment for cognitive status was not completed.

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Section D0100. (Mood) of the MDS documented the following: "Should Resident Mood Interview be Conducted?"

Dashes "-" were coded for sections D0100 through D0300 indicating that this assessment was not completed. Section D0500 through D0600, were also coded with dashes indicating that the staff assessment for mood was not completed.

Section E0200. (Behavioral Symptom-Presence and Frequency) documented the following: "Note presence of symptoms and their frequency:

A. Physical behavioral symptoms directed towards others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually).

B. Verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others, cursing at others).

C. Other behavioral symptoms not directed towards others- (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging..."

Dashes "-" were coded for all three prompts indicating that these behaviors were not assessed.

E0800. (Rejection of Care Presence and Frequency) documented the following: "Did the resident reject evaluation or care (e.g. bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well being? Do not include behaviors that have already been addressed...

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0. Behavior not exhibited.
1. Behavior of this type occurred 1 to 3 days.
2. Behavior of this type occurred 4 to 6 days but less than daily.
3. Behavior of this type occurred daily."

A dash "-" was documented for this section indicating the assessment was not completed.

E0900. (Presence and Frequency) documented the following: "Has the resident wandered?

0. Behavior not exhibited.
1. Behavior of this type occurred 1 to 3 days.
2. Behavior of this type occurred 4 to 6 days but less than daily.
3. Behavior of this type occurred daily."

A dash "-" was documented for this section indicating the assessment was not completed.

On 4/21/16 at 8:50 a.m., an interview was conducted with OSM (Other Staff Member) #2, the social worker. She stated that she was responsible for completing sections C, D, and E on the MDS assessments. She stated that dashes on the MDS assessment meant that the section was not assessed. She confirmed that section C, D, and E for Resident #9 was not completed. She stated that she had missed it. She stated that she uses the RAI (Resident Assessment Instrument Manual) as a reference.

On 4/20/16 at 6:04 p.m., administration was made aware of the above findings. No further information was presented prior to exit.

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The MDS 3.0 RAI manual documents the following for section C, D and E:
1. "Section C (Cognitive Patters): Steps for Assessment:
1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0700 - C1000, Staff Assessment of Mental Status.
2. Review Language item (A1100), to determine if the resident needs or wants an interpreter. If the resident needs or wants an interpreter, complete the interview with an interpreter.
Code 0, no: if the interview should not be attempted because the resident is rarely/never understood or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.
Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.
C0500. Summary Score (Cognitive Status)
Code 99, unable to complete interview: if (a) the resident chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response, or (c) if any of the BIMS items is coded with a dash.
Note: a zero score does not mean the BIMS was incomplete. To be incomplete, a resident had to choose not to answer or give completely unrelated, nonsensical responses to four or more items.
Coding Instructions for Section C0600. (Staff Assessment of Cognitive Status)
Code 0, no: if the BIMS was completed and scored between 00 and 15. Skip to C1300.
Code 1, yes: if the resident chooses not to

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participate in the BIMS or if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response.
Continue to C0700-C1000 and perform the Staff Assessment for Mental Status. Note: C0500 should be coded 99.
2. Coding Instructions for D0100. (Mood)
Code 0, no: if the interview should not be conducted. This option should be selected for residents who are rarely/never understood, or who need an interpreter (A1100 = 1) but one was not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).
Code 1, yes: if the resident interview should be conducted. This option should be selected for residents who are able to be understood, and for whom an interpreter is not needed or is present. Continue to item D0200, Resident Mood Interview.
Coding Instructions for D0300. (Mood Total Score)
Steps for Assessment After completing D0200:
Add the numeric scores across all frequency items in Resident Mood Interview (D0200) Column 2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview. The maximum resident score is 27 (3 x 9).
Coding for D0500. (Staff Assessment for Mood)
Alternate means of assessing mood must be used for residents who cannot communicate or refuse or are unable to participate in the PHQ-9© Resident Mood
Coding for D0600. (Staff Assessment for Mood Total Score)
Add the numeric scores across all frequency items for Staff Assessment of Mood, Symptom Frequency (D0500) Column 2. Maximum score is 30 (3 × 10).

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3. Coding Instructions for Section E0200 (Behavioral Symptoms), E0800 (Rejection of Care) and E0900 (Wandering)
Code 0, behavior not exhibited: if the behavioral symptoms were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7 days.
Code 1, behavior of this type occurred 1-3 days: if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days.
Code 2, behavior of this type occurred 4-6 days, but less than daily: if the behavior was exhibited 4-6 of the last 7 days, regardless of the number or severity of episodes that occur on any of those days.
Code 3, behavior of this type occurred daily: if the behavior was exhibited daily, regardless of the number or severity of episodes that occur on any of those days."

3. The facility staff failed to assess and accurately code Resident #2's dental status on the resident's significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/29/16.

Resident #2 was admitted to the facility on 4/9/99. Resident #2's diagnoses included but were not limited to: malignant neoplasm (cancer) (1) of cheek mucosa (tissue) (2), hemiplegia (paralysis) (3), dysphagia (swallowing disorder) (4) and aphasia (disorders caused by damage to the part of the brain responsible for language control) (5).

Resident #2's most recent MDS (minimum data set), a significant change in status assessment

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with an ARD (assessment reference date) of 2/29/16, coded the resident's cognition as being severely impaired. Section G coded Resident #2 as requiring extensive assistance of one staff with bed mobility, transfers, dressing and personal hygiene. Section G further documented the resident required supervision and set up help with eating. Section L coded Resident #2 as not having abnormal mouth tissue, cavities, broken teeth, inflamed/bleeding gums, or loose teeth. L0200G "Dental- none of the above" was coded.

ENT (ear nose and throat) consult notes for Resident #2 revealed notes dated 4/30/15 and 5/14/15 with a documented diagnosis of a cancerous ulcerative lesion of the left buccal (cheek) mucosa for which Resident #2 underwent surgery on 6/8/15. The ENT notes documented the wound was partially reopened on 7/14/15 and the wound was well healed on 4/19/16.

On 4/20/16 at 10:15 a.m., an interview was conducted with LPN (licensed practical nurse) #2 regarding oral assessments. LPN #2 was asked to describe Resident #2's teeth. LPN #2 stated the resident had oral cancer and her teeth were kind of discolored. LPN #2 stated the resident was missing some teeth.

On 4/20/16 at 12:45 p.m., observation of Resident #2's teeth was conducted with LPN #2 (permission was obtained from the resident). The resident's bottom teeth presented with an off white yellowish color. Some back teeth were missing and some fillings were observed. No chips or cracks were observed. Resident #2's top teeth presented with an off white yellowish color. Some black discoloration was also noted. Missing teeth were observed in the back and right

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front side of the resident's mouth. No chips or cracks were observed. All observations were confirmed with LPN #2.

On 4/20/16 at 5:10 p.m., an interview was conducted with RN (registered nurse) #3 (the MDS coordinator). RN #3 was asked if Resident #2 had any issues with her teeth/mouth. RN #3 stated, "Not to my knowledge." RN #3 was asked where she obtains information to code section L of the MDS. RN #3 stated she obtains the documentation from nursing documentation and from her observations when completing the pain interview with residents. RN #3 was asked if she had ever seen the inside of Resident #2's mouth and confirmed she had not. At this time, RN #3 was made aware of Resident #2's ENT consult notes and this surveyor's observations of the resident's teeth. RN #3 was shown section L of Resident #2's MDS and confirmed the assessment was not accurate. RN #3 stated she references the RAI (resident assessment instrument) manual when completing MDS assessments.

On 4/20/16 at approximately 6:00 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The CMS (Centers for Medicare and Medicaid Services) RAI manual documented:

"SECTION L: ORAL/DENTAL STATUS
Intent: This item is intended to record any dental problems present in the 7-day look-back period.
L0200: Dental
DEFINITIONS
CAVITY

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A tooth with a discolored hole or area of decay that may have debris in it.
BROKEN NATURAL TEETH OR TOOTH FRAGMENT
Very large cavity, tooth broken off or decayed to gum line, or broken teeth (from a fall or trauma).
ORAL LESIONS
A discolored area of tissue (red, white, yellow, or darkened) on the lips, gums, tongue, palate, cheek lining, or throat.
ORAL MASS
A swollen or raised lump, bump, or nodule on any oral surface. May be hard or soft, and with or without pain.
ULCER
Mouth sore, blister or eroded area of tissue on any oral surface.
Item Rationale
Health-related Quality of Life
·Poor oral health has a negative impact on:
- quality of life
- overall health
- nutritional status
·Assessment can identify periodontal disease that can contribute to or cause systemic diseases and conditions, such as aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.
Planning for Care
·Assessing dental status can help identify residents who may be at risk for aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.
Steps for Assessment
1. Ask the resident about the presence of chewing problems or mouth or facial pain/discomfort.
2. Ask the resident, family, or significant other whether the resident has or recently had dentures

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or partials. (If resident or family/significant other reports that the resident recently had dentures or partials, but they do not have them at the facility, ask for a reason.)
3. If the resident has dentures or partials, examine for loose fit. Ask him or her to remove, and examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment.
4. Conduct exam of the resident's lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth.
5. If the resident is unable to self-report, then observe him or her while eating with dentures or partials, if indicated, to determine if chewing problems or mouth pain are present.
6. Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these residents and any resident who exhibits dental or oral issues.
Coding Instructions
·Check L0200A, broken or loosely fitting full or partial denture: if the denture or partial is chipped, cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth, or the denture moves when the resident tries to talk.
·Check L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is

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edentulous or lacks all natural teeth or parts of teeth.
·Check L0200C, abnormal mouth tissue (ulcers, masses, oral lesions): select if any ulcer, mass, or oral lesion is noted on any oral surface.
·Check L0200D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen.
·Check L0200E, inflamed or bleeding gums or loose natural teeth: if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip.
·Check L0200F, mouth or facial pain or discomfort with chewing: if the resident reports any pain in the mouth or face, or discomfort with chewing.
·Check L0200G, unable to examine: if the resident's mouth cannot be examined.
·Check L0200Z, none of the above: if none of conditions A through F is present..."

No further information was presented prior to exit.

(1) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/cancer.html

(2) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/002264.htm

(3) This information was obtained from the website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=hemiplegia

(4) This information was obtained from the

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website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dysphagia

(5) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/aphasia.html

4. The facility staff failed to ensure Resident #13's quarterly MDS assessment with an ARD (assessment reference date) of 3/18/16 was correctly coded for cognition (Section C) and mood (Section D).

Resident # 13 was admitted to the facility on 7/20/15 with diagnoses including, but not limited to: neurogenic bladder, hyperlipidemia, paraplegia, atrial fibrillation, and high blood pressure.

The most recent Quarterly MDS assessment with an ARD of 3/18/16 coded Resident # 13 on Section C (Cognitive Patterns) the resident's brief interview for metal status as (--) out of 15, indicating Resident # 13's cognition interview was not completed [per MDS coordinator, RN (registered nurse) # 3]. Review of Section B "Hearing, Speech, and Vision" in Section B-0700 (Makes Self Understood) was coded as "0," Understands; and in Section B0800 (Ability To Understand Others) was coded as "0" - Understands. Review of Section D (Mood) was also coded as (--) (again indicating that the interview was not completed (per MDS

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Coordinator, RN # 3).

The most recent complete MDS, a quarterly assessment with ARD (assessment reference date) of 12/31/15, coded Resident # 13 on the resident's BIMS (brief interview for metal status) as 15 out of 15, indicating Resident #13's cognition was intact. Review of Section B "Hearing, Speech, and Vision" in Section B-0700 (Makes Self Understood) was coded as "0," Understood; and in Section B0800 (Ability To Understand Others) was coded as "0" - Understands.

An interview was conducted on 4/20/16 at 10:30 a.m., with RN # 3. The Quarterly MDS with an ARD of 3/18/16 for Resident #13 was reviewed with RN #3 and RN # 3 stated a dash (--) would indicate that the interviews were not completed. RN # 3 stated the Social Worker completes both Section C and Section D. RN # 3 further stated she uses the RAI (Resident Assessment Instrument) Manual as a reference for completing MDS.

During the end of day interview on 4/20/16 at approximately 6:00 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, ASM # 3, the regional Quality Assurance Manager, and ASM # 4 the Regional Manager, were informed of these concerns. At this time a request was made to interview the social worker when she came to work in the morning.

On 4/21/16 at 8:55 a.m. OSM (other staff member) # 2, the social worker, was interviewed regarding the above-referenced concerns and was asked what the dashes mean. OSM # 2

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stated that it meant the interview has not been done or assessed. OSM # 2 further stated, "I did not get to the interviews." OSM # 2 was asked what reference she used to complete the MDS assessment and she stated the RAI Manual.

No further information was provided prior to exit.

For Cognition the CMS (Centers for Medicaid and Medicare Services) RAI manual documented the following:

CMS's RAI (Centers for Medicaid and Medicare Services Resident Assessment Instrument) Version 3.0 Manual CH 3: MDS Items [C] states: "C0200-C0500: Brief Interview for Mental Status (BIMS)...
Steps for Assessment
1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0700 - C1000, Staff Assessment of Mental Status...
Coding Instructions
Record whether the cognitive interview should be attempted with the resident.
Code 0, no: if the interview should not be attempted because the resident is rarely/never understood or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.
Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.

Coding Tips ...
. Nonsensical responses should be coded as zero.

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· Rules for stopping the interview before it is complete:
- Stop the interview after completing (C0300C) "Day of the Week" if:
all responses have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated), OR
there has been no verbal or written response to any of the questions up to this point, OR
there has been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response.
· If the interview is stopped, do the following:
Code -, dash in C0400A, C0400B, and C0400C.
Code 99 in the summary score in C0500.
Code 1, yes in C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted?
Complete the Staff Assessment for Mental Status...

For Mood The CMS RAI manual documented the following:

"SECTION D: MOOD
Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable...

D0100: Should Resident Mood Interview Be Conducted?
Coding Instructions
·Code 0, no: if the interview should not be

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conducted. This option should be selected for residents who are rarely/never understood, or who need an interpreter (A1100 = 1) but one was not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).
·Code 1, yes: if the resident interview should be conducted. This option should be selected for residents who are able to be understood, and for whom an interpreter is not needed or is present. Continue to item D0200, Resident Mood Interview (PHQ-9©)...

D0200: Resident Mood Interview (PHQ-9©)
Coding Instructions for Column 1. Symptom Presence
·Code 0, no: if resident indicates symptoms listed are not present enter 0. Enter 0 in Column 2 as well.
·Code 1, yes: if resident indicates symptoms listed are present enter 1. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency.
· Code 9, no response: if the resident was unable or chose not to complete the assessment, responded nonsensically and/or the facility was unable to complete the assessment. Leave Column 2, Symptom Frequency, blank.
Coding Instructions for Column 2. Symptom Frequency
Record the resident's responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood. Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician.
·Code 0, never or 1 day: if the resident indicates that he or she has never or has only experienced the symptom on 1 day.
·Code 1, 2-6 days (several days): if the resident indicates that he or she has experienced the

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symptom for 2-6 days.
·Code 2, 7-11 days (half or more of the days): if the resident indicates that he or she has experienced the symptom for 7-11 days.
·Code 3, 12-14 days (nearly every day): if the resident indicates that he or she has experienced the symptom for 12-14 days...

D0300: Total Severity Score
Coding Instructions
·The interview is successfully completed if the resident answered the frequency responses of at least 7 of the 9 items on the PHQ-9©.
·If symptom frequency is blank for 3 or more items, the interview is deemed NOT complete. Total Severity Score should be coded as '99' and the Staff Assessment of Mood should be conducted.
·Enter the total score as a two-digit number. The Total Severity Score will be between 00 and 27 (or "99" if symptom frequency is blank for 3 or more items).
·The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, see Appendix E: PHQ-9© Total Severity Score Scoring Rules..."

5. The facility staff failed to correctly code that Resident #22 was receiving oxygen therapy on the five day admission MDS (minimum data set) assessment dated 7/28/15.

Resident #22 was admitted to the facility on 7/21/15 and discharged on 7/30/15 with diagnoses that included but were not limited to: anemia, lung disease, atrial fibrillation (an irregular heartbeat) and heart failure.

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Resident #22's most recent MDS, a five day assessment, with an ARD (assessment reference date) of 7/28/15 coded the resident as having a BIMS (brief interview of mental status) of 15 out of 15 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance with activities of daily living except for eating which the resident could do independently after the meal tray was prepared.

Review of the physician's orders dated and signed on 7/21/15 documented, "OXYGEN: HUMIDIFIED 3l (liters)/min (minute) via nasal cannula (soft plastic prongs that fit in the nose) as needed for sob (shortness of breath)."

Review of the nurse's notes from 7/21/15 to 7/29/15 documented on multiple occasions that the resident was receiving oxygen via nasal cannula.

Review of Resident #22's MAR (medication administration record) documented, "OXYGEN: HUMIDIFIED via nasal cannula; as needed for sob for 3l/min. Start 7/21/15..." The record did not evidence documentation that oxygen had been used.

Review of the resident's care plan dated 7/22/15 documented, "COPD (chronic obstructive pulmonary disease). 7/22 O2 (oxygen) 3L PRN (as needed) + via CPAP* (continuous positive airway pressure) @ NIGHT."

Review of the five day assessment MDS dated 7/28/15 in section O titled "Special Treatment, Procedures, and Programs" documented under

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"Respiratory Treatments C. Oxygen therapy. Check all that apply." The box for the oxygen therapy was blank.

An interview was conducted on 4/21/16 at 10:34 a.m. with RN (registered nurse) #3, the MDS coordinator. When asked who was responsible for completing section O, respiratory treatments, RN #3 stated, "The MDS coordinator does that." When asked how the information was collected to complete that section, RN #3 stated, "From the notes, the orders, hospital record, the MAR and TAR (treatment administration record)." When asked what time period she used for the look back period to collect the data, RN #3 stated, "Fourteen days since it's an admission." When asked to review the respiratory therapy section of the five day MDS and explain what the blank box indicated, RN #3 stated, "That they didn't get it (oxygen)." RN #3 was asked to review the nurse's notes from 7/21/15 to 7/29/15 documenting that the resident was receiving oxygen therapy. When asked if that the resident should have been coded on the MDS for oxygen therapy, RN #3 stated, "Yes." When asked if she had any idea why it did not get coded, RN #3 stated, "I do not." When asked what policy the MDS coordinators used to complete the MDS RN #3 stated, "The RAI (resident assessment instrument)."

On 4/21/16 at 11:05, ASM (administrative staff member) #2, the director of nursing was made aware of the findings.

No further information was provided prior to exit.

*CPAP, or continuous positive airway pressure, is a treatment that uses mild air pressure to keep the airways open. CPAP typically is used by

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F 278	Continued From page 40 people who have breathing problems, such as sleep apnea </health/health-topics/topics/sleep apnea/> http://www.nhlbi.nih.gov/health/health-topics/topics/cpap/	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards for one of 29 residents in the survey sample, Resident #14. The facility staff failed to transcribe a verbal order for tube feeding from a nurse practitioner to the electronic medical record for Resident #14. The findings include: Resident #14 was admitted to the facility on 4/7/16 with diagnoses including, but not limited to: history of a stroke, chronic obstructive pulmonary disease, Bipolar disorder, and heart disease. The resident had not been in the facility long enough for an MDS (minimum data set) to be submitted. A review of his admission nursing assessment dated 4/8/16 revealed that the resident had difficulties understanding and being understood by others. The assessment revealed that Resident #14 had a PEG (Percutaneous endoscopic gastrostomy tube *) tube in place.	F 281	F Tag 281 Resident #14 received orders from physician services during survey for tube feeding to be at 50mls/hour. All residents receiving tube feedings have the potential to be affected by this practice. The DON and ADON will in service licensed staff on guidelines for medication orders to include verbal orders.	

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F 281	Continued From page 41 On 4/19/16 at 2:30 p.m., Resident #14 was observed lying in his bed with the head of bed elevated. A tube feeding was being administered through the PEG tube at the rate of 50 mls (milliliters)/hour. Observations on 4/20/16 at 8:10 a.m. and 11:40 a.m. revealed the resident in a similar position in bed with the tube feeding at the same rate of 50 mls/hour. A review of Resident #14's clinical record revealed the following order dated and signed by the nurse practitioner on 4/18/16: "Restart tube feeding [name of tube feeding product] at 40 ml/h (milliliters/hour) and 300 ml water flush q 4 h (every four hours)." A review of the resident's April 2016 MAR (medication administration record) revealed no evidence of this order. The most recent entry on the MAR documented: "Enteral feeding continuous for 24 hours at 50 ml/hour." On 4/10/16 at 11:40 a.m., LPN (licensed practical nurse) #2 accompanied this surveyor to the resident's bedside. When asked to verify the rate of the tube feeding, he stated: "It's running at 50 per hour." When asked if he was aware of the rate currently ordered, he stated: "It's 50." When LPN #2 checked Resident #14's chart and saw the above-referenced order, he stated: "Uh oh. I didn't realize the order had changed. Someone didn't take the order off." He stated that he would call the physician. When asked the process for checking a tube feeding rate, he stated: "I go by the orders that are in the computer." LPN #2 stated the paper order in the chart for 40 mls/hour had not been transcribed to the computer, so he did not know that the rate had changed from 50	F 281	The Unit Managers will complete an audit of residents with tube feed orders to ensure they are receiving prescribed amount and rate. The DON or designee will continue to audit all new orders and admissions 5x/week for 4 weeks to ensure accuracy. Any variances will be corrected and continuing education provided. The results of these audits will be reported to the DON. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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mls/hour to 40 mls/hour.

On 4/20/16 at 1:45 p.m., RN (registered nurse) #1 was interviewed regarding the process for transcribing a verbal order to the electronic record. She stated: "You take off the order. You put the [verbal order] into the system. You print it out for signature. It goes straight from the computer to the pharmacy." When shown the above-referenced verbal order for Resident #14, she stated: "I must not have seen this. I did not take it off. That's my error."

A review of Resident #14's care plan dated 4/20/16 revealed, in part, the following: "Tube feeding as ordered."

On 4/20/16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional quality assurance manager, and ASM #4, the regional manager, were informed of these concerns.

On 4/21/16 at 10:25 a.m., ASM #3 provided the surveyor with a document entitled "Guidelines for Medication Orders." She stated: "We refer to this policy as our professional standard of practice." A review of this document revealed, in part, the following: "New Verbal Orders: The nurse documents a complete order received by telephone or in person on the appropriate pharmacy approved form...The nurse must indicate the prescriber's name giving the order and the licensed nurse accepting/recording the order. The nurse will sign the order in the appropriate space on the verbal order form...The pharmacy can only accept orders written on pharmacy approved forms/systems...If a physician or nurse practitioner writes an order in

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F 281	Continued From page 43 the Facility, a nurse in the Facility transcribes or enters the complete order onto the medication or treatment administration record or electronic medical records system." According to Fundamentals of Nursing, Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. Be sure to look for order duplications that could cause your patient to receive a medication in error...." No further information was provided prior to exit. *PEG tube - "Percutaneous endoscopic gastrostomy tube - a tube placed in the stomach for the purpose of temporary or permanent nutrition." This information is taken from the website www.nlm.nih.gov.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility document review, and clinical record review, it was determined that the facility staff failed provide care in accordance with the written plan of care for three of 29 residents in the survey	F 282		

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sample, Residents #11, #6, and #1.

1. The facility staff failed to follow the written plan of care for the treatment of Resident #11's pressure ulcers.

2. The facility staff failed to follow Resident #6's care plan to provide needed dental services.

3. The facility staff failed to apply a fleece protective pad on Resident #1's right arm when seated in her wheelchair as directed in the care plan. Resident #1 was observed without the fleece pad in place for two days.

The findings include:

1. The facility staff failed to follow the written plan of care for the treatment of Resident #11's pressure ulcers.

Resident #11 was admitted to the facility on 3/28/16 with diagnoses that included but were not limited to: fractured right hip, respiratory failure, aspiration pneumonia, neurogenic bladder and a history of uterine cancer.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 4/4/16, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) indicating the resident was capable of making 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 eating in which

Resident #11 has a pressure reducing surface in place in the wheelchair. Rest periods are being offered. The pressure ulcer has resolved.

Resident #6 had dental services prior to survey and will be offered services as needed in the future.

Resident #1- A physician's order was written to discontinue the fleece protective pad. The care plan has been updated to reflect this.

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

The Unit Managers will audit residents that currently have pressure ulcers, dental services, and protective equipment to ensure care plans are written and reflect current care being provided.

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F 282	Continued From page 45 she required set up assistance. In Section M - Skin Conditions, the resident was coded as having one Stage II pressure ulcer and one unstagable - deep tissue injury wound. A stage II pressure ulcer is described as partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture). May also present as an intact or open/ruptured blister. (1) A deep tissue injury if a nonblanchable purple or maroon discoloration of intact skin that may indicate damage to the underlying tissue. (2) Review of the comprehensive care plan dated, 4/12/16, documented, "Problems: Actual impaired skin integrity related to Sacral Wound." The "Approaches" documented in part, "Measure area weekly and document it's characteristics in the skin log. Provide assistance to reposition frequently and as needed." The care plan documented, "Problem: Potential for impaired skin integrity r/t (related to) decline in function and mobility, incontinent episodes, current skin breakdown and diagnosis." The "Approaches" documented in part, "Limit the time sitting in chair." The comprehensive care plan dated, 4/14/16 documented in part, "Problem: Actual impaired skin integrity related to heel wound." The "Approaches" documented in part, "Measure area weekly and document its characteristics." Resident #11 was observed on 4/19/16 at 12:03 p.m. and 3:32 p.m. in her wheelchair. A resident interview was conducted with Resident #11 on 4/19/16 at 3:32 p.m. The resident stated, "My bottom is sore and has been sore since I got	F 282	The DON and ADON will in service licensed staff on written care plans, writing goals and utilizing the care to communicate the care each resident receives along with updating the care plan for any changes in resident's condition. The Unit Managers will audit new admissions and new orders 5x/week for 4 weeks to ensure any changes are placed on the care plan. The results will be reported to the DON. Any variances will be corrected and continued education provided. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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F 282	Continued From page 46 here. They did change the treatment today." The resident was observed on 4/20/16 at 12:49 p.m. sitting in her wheelchair. The speech therapist was working with her. An observation was made of Resident #11's sacral wound and heel wound on 4/20/16 at 1:30 p.m. with the resident in bed with LPN (licensed practical nurse) #11 and LPN #12. The sacrum revealed three open areas. The areas were measured by the facility staff as: 1 x .5 cm, .5 x .5 cm, and 1.6 x .6 cm. When asked why the areas were not measured prior to today (the day of observation of the wound) LPN #11 stated, "She had so many open areas so we didn't measure them all." LPN #11 was asked how staff could tell if the wounds were healing if no measurements were being obtained. LPN #11 stated, "Well, if there are so many areas, how am I to measure them?" When asked about measuring the heel wound, LPN #11 stated, "I can only go by what I see each week on Fridays, I didn't do the initial assessment." After the observation was completed, LPN #12 asked Resident #11 if she wanted to stay off her bottom, and she stated, "Yes, that would be great." When the resident was asked if she normally takes a rest every day in bed, she stated, "No." Resident #11 was observed on 4/21/16 at 8:16 a.m. in her wheelchair. The resident was asked if she had been offered to go back to bed to get off her bottom, in the afternoons prior to 4/20/16. Resident #11 stated, "No, the first time was yesterday (4/20/16). It's actually the first time they (facility staff) ever suggested I go to bed to get off my bottom."	F 282		

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Review of the "Pressure Ulcer Record" dated 3/28/16, documented, "Description - Stage II sacrum slight opened." No measurements were documented. It did document no undermining, odor, or drainage. The color was documented as "red." Under the heading, "Length/Width/Depth in cm (centimeters) was documented, "UM (unmeasurable)." For each weekly measurements on 4/2/16, 4/8/16 and 4/15/16, a "UM" was documented under this column.

Review of the "Pressure Ulcer Record" dated, 3/28/16, documented, "Description - (L) (left) heel, soft, boggy, red, purple." The "Stage" documented, "DTI (deep tissue injury). No measurements were documented. It did document no undermining, odor or drainage and the color was documented as, "red, purple." Under the heading, "Length/Width/Depth in cm (centimeters) was documented, "UM." For each weekly measurements on 4/2/16, 4/8/16 and 4/15/16, a "UM" was documented under this column.

Review of the "Nursing Admission Assessment" dated; 3/29/16 at 1:16 a.m. did not reveal any documentation on the pressure ulcers.

The nurse's notes dated 3/28/16 through 4/19/16 were reviewed. On 3/28/16 at 3:48 p.m. it was documented, "Guest has 2 skin issues noted." There was no other documentation regarding the pressure ulcers.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 4/20/16 at 1:58 p.m. When asked if a pressure ulcer, described as a Stage II should be

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measured, ASM #2 stated, "If it's measureable. It would depend on where it's located anatomically. Would have to see it to tell you that answer."

An interview was conducted with ASM #3, the regional QA (quality assurance) manager, on 4/20/16 at 2:04 p.m. When asked if a Stage II pressure area should be measured, "ASM #3 stated, "Yes." When asked if a deep tissue injury should be measured, ASM #3 stated, "I would."

An interview was conducted with CNA (certified nursing assistant) #8 on 4/21/16 at 12:21 p.m. When asked what a care plan is, CNA #8 stated, "It's the plan of treatment for a guest." When asked if there anything on the care plan that should be followed for a resident with a pressure ulcer, CNA #8 stated, "In those incidences we always lay them down after lunch." When asked if she looks at the care plan, CNA #8 stated, "No, it's in the chart."

An interview was conducted with LPN #12 on 4/21/16 at 12:24 p.m. When asked what a care plan is, LPN #12 stated, "It's how you implement the care in order to follow through and have an outcome for the resident." When asked how the information on the care plan is communicated to the CNA caring for a resident, LPN #12 stated, "We give them report." When asked who is responsible for providing this information to the CNA, LPN #12 stated, "The nurse. Honestly, they add things to those care plans and don't tell us."

The facility policy, "Interdisciplinary Care Plan" documented, "Policy: It is the policy of this facility to develop an interdisciplinary care plan for each guest that includes measurable goals and time frames directed toward achieving and maintaining

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each guest's optimal medical, physical, mental and psychosocial needs...Procedure: 2. The interdisciplinary care plan will: a. incorporate identified problem areas. b. incorporate risk factors associated with identified problems. c. build on the guest's strengths. d. reflect treatment goals and objectives in measurable outcomes. e. identify the professional services that are responsible for each element of care and frequency of services provided. f. Prevent decline in the guest's functional status and/or functional levels, g. enhance the optimal functioning of the guest by focusing on a rehabilitation program."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

The administrator was informed of the above concern on 4/21/16 at 12:15 p.m.

(1) This information was obtained from: Centers for Medicare & Medicaid Services; Long-Term Care Facility Resident Assessment Instrument User's Manual; Version 3.0 July 2010, pages M-15, M-18, M-2.
(2) This information was obtained from the website:http://www.ncbi.nlm.nih.gov/core/lw/2.0/ht

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2. The facility staff failed to follow Resident #6's care plan to provide needed dental services.

Resident #6 was admitted to the facility on 5/7/11 with diagnoses including, but not limited to: Bipolar disorder, seizure disorder, Schizophrenia, dementia, heart disease, and depression. On the most recent MDS (minimum data set), a significant change assessment with ARD (assessment reference date) 2/10/16, she was coded as having moderate cognitive impairment for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was coded as having broken teeth.

On 4/20/16 at 8:10 a.m., Resident #6 was observed sitting up in bed in her room. When the resident smiled, the surveyor observed that she had multiple chipped/broken/missing teeth. An attempt to interview the resident about her dental status was unsuccessful due to Resident #6's nonsensical responses.

A review of Resident #6's clinical record revealed a nurse's note written 11/12/15 by LPN (licensed practical nurse) #1. The note stated, in part: "Guest commented that she eats all of her food but that she only has one tooth. RD (registered dietician) made aware and diet downgraded to mechanical soft."

Further review revealed the following note written by OSM (other staff member) #1, the registered

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dietician, on 12/2/15: "Diet has been liberalized from Heart Healthy and texture has been changed to mechanical soft due to poor dentition."

Further review revealed the following note written by the nurse practitioner on 12/11/15: "[Resident #6] states difficulty chewing, no difficulty swallowing. Ordered dental consult." The record review revealed no evidence the nurse practitioner actually ordered the consult, and attempts to interview the nurse practitioner during the survey were unsuccessful.

Further review revealed the following note written on 2/9/16 by OSM #2, the social worker: "Guest (sic) family is looking to have residents (sic) teeth looked at. Guest has Medicaid and I provided a number to the unit manager for [name of local dentist] to call and make an appointment."

A review of the clinical record revealed the following note written by the nurse practitioner on 3/18/16: "Weight loss over several months due to self-restricting diet to fruit and cottage cheese due to dental issues. Brother took her to DDS (dentist) 3/16/16 and she had #7 and #26 extracted."

A review of the comprehensive care plan for Resident #6 dated 2/22/16 revealed, in part, the following: "Alteration in dental status related to: some of natural teeth missing, broken/loose/carious teeth....Dental consults as needed."

On 4/20/16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional quality

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assurance manager, and ASM #4, the regional manager, were informed of these concerns.

On 4/21/16 at 8:35 a.m., OSM #2, the social worker, was interviewed regarding the process for obtaining dental consults for residents. She stated: "I don't really get involved in that. If someone needs a phone number or something, I will get them the number. The nurses do the calling and set the appointments." When shown the above referenced note (2/9/16) and asked what she remembered about Resident #6's dental situation, she stated: "The guest's son contacted me to let me know." She stated that she thought it was the son's job to make the appointment for the resident. She stated: "I gave the son the number." When asked if she followed up to see if the son made the appointment in a timely manner, she stated, "No I didn't. I assumed he would make the call. I gave him the number of a dentist who takes Medicaid and that's the last I heard of it." When asked if she was aware that Resident #6 had been losing weight since November 2015, she stated: "Sometimes I went to the care plan meetings. But now I don't much anymore." She stated she did not have a memory of the weight loss coming up in any discussions with other staff members. When asked to review her note again and to explain the discrepancy between what she had just told the surveyor (that she gave the resident's son the phone number) and what her note stated (that she gave the phone number to the unit manager [LPN #1], she stated: "Oh. Well, maybe it was the unit manager who asked for the number. I'm assuming that I talked to the unit manager, not the son." When asked if she specifically remembered a conversation with the resident's son about the resident's dental needs, she stated:

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"Now that you mention it, not really. [LPN #1] probably brought it up in an evening meeting."

On 4/21/16 at 8:45 a.m., LPN #1 was interviewed regarding the process for obtaining dental services for residents. She stated: "We don't have a dentist who comes here." She stated that she becomes aware of needs for dental services from residents themselves or from families. She stated: "Most of our residents are on Medicaid. The nurses are responsible for calling the dentists and setting up transportation." When shown the progress note from the nurse practitioner dated 12/11/15, she stated: "This is the first time I'm seeing this. It's just a note. I don't see an order." When asked what she remembered about Resident #6's dental consult resulting in tooth extraction on 3/16/16, she stated: "I can't tell you. We don't keep the paperwork. I don't know when the appointment was actually made." She stated she would "do some checking" and let the surveyor know what she found out. On 4/21/16 at 11:05 a.m., she stated: "I don't have any notes or any information. I don't know why it took so long for us to get her a dental consult."

On 4/21/16 at 11:05 a.m., RN (registered nurse) #1 was interviewed regarding the process for following a resident's care plan. She stated: "Resident needs would be my priority." When asked about obtaining needed dental services, she stated: "Somebody needs to assess if there is a need." She stated that the care plan is a guide, and identifies the possible needs a resident may have. She stated that it guides the staff in looking for things a resident might need. She stated that the direct care staff (in this case, nurses) are responsible for implementing this part

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THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

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of a care plan.

A review of the facility policy entitled "Interdisciplinary Care Plan" revealed no information specific to following a resident's care plan.

No further information was provided prior to exit.

3. The facility staff failed to apply a fleece protective pad on Resident #1's right arm when seated in her wheelchair as directed in the care plan. Resident #1 was observed without the fleece pad in place for two days.

Resident #1 was admitted to the facility on 6/10/14 with diagnoses that included, but were not limited to, CVA (cerebral vascular accident - a stroke), HTN (hypertension - high blood pressure), obesity, hyperlipidemia (elevated lipids in the blood stream), diabetes, sleep apnea and expressive aphasia (difficulty speaking).

Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/10/16. Resident #1 was coded on the MDS as having a BIMs (Brief Interview for Mental Status) score of 7 out of 15. The MDS manual documents that a score of 7 indicates that the resident's cognition is severely impaired.

A review of Resident #1's clinical record revealed a care plan dated 6/18/15 documenting, in part, the following entry:
"Onset: 7/7/15. Problems/Conclusions: Skin: Potential for impaired skin integrity related to

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decreased ADL (activities of daily living) ability, incontinence, decreased mobility. Measurable Goals: Skin will remain intact for next 90 days. Goal LT (long term): Reviewed 5/24/16. Approaches/Interventions: Use fleece elbow protector to R (right) elbow. Start 7/7/15."

Resident #1 was observed on the following dates and times sitting in her wheelchair with a lap tray to rest her right arm on and there was no fleece protector on her right elbow: 4/19/16 at 4:00 p.m.; 4/20/16 at 11:25 a.m.; 4/20/16 at 4:30 p.m.

Further review of Resident #1's clinical record revealed a POS (physician order sheet) documenting, in part, "active orders (4/1/16 - 4/30/16)." The following order was documented: "Start: 2/1/16 End 6/18//17. Active Recertified 3/31/16. Treatment: fleecee (sig) protector to right elbow q (every) shift while in wc (wheelchair) every shift every shift (sic) (day, eve (evening), night). Telephone order from (name of physician) taken by (name of nurse)."

A review of Resident #1's TARs (treatment administration record) for the month of April 2016 revealed, in part, the following treatment; "Treatment every shift for Start: 2/1/16 3:57 am (morning). DC (discontinue) 4/20/16 04:54 pm (evening). Extended Directions: fleecee (sic) protector to right elbow q shift while in wc every shift." On 4/19/16 a nurse initialed that the fleece protector was on Resident #1's right elbow on day shift, evening shift and night shift. On 4/20/16 a nurse initialed that the fleece protector was on Resident #1's right elbow on dayshift.

On 4/20/16 at 4:45 p.m. an interview was conducted with LPN (licensed practical nurse)

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#16. LPN #16 was asked who was caring for Resident #1 on that day. LPN #16 responded that she was caring for Resident #1. LPN #16 was asked whether or not she was aware of any special equipment that Resident #1 was to have each day. LPN #16 referred to her computer system and stated, "(Resident #1) has an order for a fleece elbow protector to be placed on her right elbow." LPN #16 was asked who was responsible for checking that the fleece elbow pad was in place. LPN #16 responded that everyone was responsible. LPN #16 was asked whether or not the fleece elbow pad was checked off today as being on Resident #1. LPN #16 responded, "It is." LPN #16 was asked whether or not she had noticed it being on Resident #1, LPN #16 responded that she had just checked Resident #1's blood sugar but hadn't noticed whether or not the fleece elbow pad was or wasn't on. LPN #16 added, "It is supposed to be on." At this time LPN #16 accompanied this surveyor to look at Resident #1 who was sitting in her wheelchair in the dining room. Resident #1 was not wearing the fleece elbow pad to her right elbow. LPN #16 spoke with Resident #1 then stated, "(Resident #1) does not want it on, it should be discontinued." LPN #16 stated that she would contact the physician and get it discontinued since the resident was refusing to wear it. LPN #16 was asked why it was documented on the TAR that it was on the resident. LPN #16 stated, "it should not be documented as on if it is not being placed on her arm."

A review of the facility policy titled "Interdisciplinary Care Plan" revealed, in part, the following documentation: "2. The interdisciplinary care plan will: e. Identify the

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F 282	Continued From page 57 professional services that are responsible for each element of care and frequency of services provided." At an end of the day meeting on 4/20/16 at 5:50 p.m. ASM (administrative staff member) #1, the facility administrator; ASM #2, the director of nursing; ASM #3, the regional QA (quality assurance manager) and ASM #4, the regional manager; were made aware of the above findings. No further information was provided prior to the end of the survey.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and the clinical record review, it was determined that the facility staff failed to provide care and services to promote the highest level of well-being for one of 29 residents in the survey sample, Resident #1. The facility staff failed to place a fleece elbow pad on Resident #1's right elbow as ordered by the physician.	F 309		

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F 309	Continued From page 58 The findings include: The facility staff failed to place a fleece elbow pad on Resident #1's right elbow as ordered by the physician. Resident #1 was admitted to the facility on 6/10/15 with diagnoses that included, but were not limited to, CVA (cerebral vascular accident - a stroke), HTN (hypertension - high blood pressure), obesity, hyperlipidemia (elevated lipids in the blood stream), diabetes, sleep apnea and expressive aphasia (difficulty speaking). Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/10/16. Resident #1 was coded on the MDS as having a BIMs (Brief Interview for Mental Status) score of 7 out of 15. The MDS manual documents that a score of 7 indicates that the resident's cognition is severely impaired. A review of Resident #1's clinical record revealed a care plan dated 6/18/15 documenting, in part, the following entry: "Onset: 7/7/15. Problems/Conclusions: Skin: Potential for impaired skin integrity related to decreased ADL (activities of daily living) ability, incontinence, decreased mobility. Measurable Goals: Skin will remain intact for next 90 days. Goal LT (long term): Reviewed 5/24/16. Approaches/Interventions: Use fleece elbow protector to R (right) elbow. Start 7/7/15." Resident #1 was observed on the following dates and times sitting in her wheelchair with a lap tray to rest her right arm on and there was no fleece protector on her right elbow: 4/19/16 at 4:00	F 309	F Tag 309 An order was obtained from the physician to discontinue the order for the fleece elbow protector due to resident #1's preference. Residents with orders for protective devices have the potential to be affected by this practice. The Unit Managers will complete an audit of devices currently ordered for residents to ensure the plan of care is being followed and updated as needed. The results will be reported to the DON and any variances will be corrected and continued education provided. The DON and ADON will complete in- servicing to licensed staff on providing care and services to promote the highest level of well – being to include protective devices.	

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F 309	Continued From page 59 p.m.; 4/20/16 at 11:25 a.m.; 4/20/16 at 4:30 p.m. Further review of Resident #1's clinical record revealed a POS (physician order sheet) documenting, in part, "active orders (4/1/16 - 4/30/16)." The following order was documented: "Start: 2/1/16 End 6/18//17. Active Recertified 3/31/16. Treatment: fleecee (sic) protector to right elbow q (every) shift while in wc (wheelchair) every shift every shift (sic) (day, eve (evening), night). Telephone order from (name of physician) taken by (name of nurse)." A review of Resident #1's TARs (treatment administration record) for the month of April 2016 revealed, in part, the following treatment; "Treatment every shift for Start: 2/1/16 3:57 am (morning). DC (discontinue) 4/20/16 04:54 pm (evening). Extended Directions: fleecee (sic) protector to right elbow q shift while in wc every shift." On 4/19/16 a nurse initialed that the fleece protector was on Resident #1's right elbow on day shift, evening shift and night shift. On 4/20/16 a nurse initialed that the fleece protector was on Resident #1's right elbow on dayshift. On 4/20/16 at 4:45 p.m. an interview was conducted with LPN (licensed practical nurse) #16. LPN #16 was asked who was caring for Resident #1 on that day. LPN #16 responded that she was caring for Resident #1. LPN #16 was asked whether or not she was aware of any special equipment that Resident #1 was to have each day. LPN #16 referred to her computer system and stated, "(Resident #1) has an order for a fleece elbow protector to be placed on her right elbow." LPN #16 was asked who was responsible for checking that the fleece elbow pad was in place. LPN #16 responded that	F 309	The Unit Mangers will audit new admissions and new orders 5x/week for 4 weeks to ensure devices are reflected on the current plan of care. The Unit Managers will conduct rounds 2x/day 5x/week to ensure devices are appropriately placed on residents with orders. Any variances will be corrected and continued education provided. The results of audits will be reported to the DON. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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everyone was responsible. LPN #16 was asked whether or not the fleece elbow pad was checked off today as being on Resident #1. LPN #16 responded, "It is." LPN #16 was asked whether or not she had noticed it being on Resident #1, LPN #16 responded that she had just checked Resident #1's blood sugar but hadn't noticed whether or not the fleece elbow pad was or wasn't on. LPN #16 added, "It is supposed to be on." At this time LPN #16 accompanied this surveyor to look at Resident #1 who was sitting in her wheelchair in the dining room. Resident #1 was not wearing the fleece elbow pad to her right elbow. LPN #16 spoke with Resident #1 then stated, "(Resident #1) does not want it on, it should be discontinued." LPN #16 stated that she would contact the physician and get it discontinued since the resident was refusing to wear it. LPN #16 was asked why it was documented on the TAR that it was on the resident. LPN #16 stated, "it should not be documented as on if it is not being placed on her arm."

A review of the facility policy titled "Interdisciplinary Care Plan" revealed, in part, the following documentation: "2. The interdisciplinary care plan will: e. Identify the professional services that are responsible for each element of care and frequency of services provided." There was no documentation in the care plan evidencing Resident #1 refused to wear the fleece pad on her right elbow.

A review of Resident #1's nursing notes did not reveal any documentation to evidence that Resident #1 refused to wear the fleece pad on her right elbow.

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F 309	Continued From page 61 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." At an end of the day meeting on 4/20/16 at 5:50 p.m. ASM (administrative staff member) #1, the facility administrator; ASM #2, the director of nursing; ASM #3, the regional QA (quality assurance manager) and ASM #4, the regional manager; were made aware of the above findings. No further information was provided prior to the end of the survey	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to implement restorative nursing services for one of 29 residents in the survey sample, Resident #2. The facility staff failed to implement Resident #2's restorative feeding program per the resident's written plan of care on 4/20/16 and 4/21/16.	F 311		

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F 311	Continued From page 62 The findings include: Resident #2 was admitted to the facility on 4/9/99. Resident #2's diagnoses included but were not limited to: malignant neoplasm (cancer) (1) of cheek mucosa (tissue) (2), hemiplegia (paralysis) (3), dysphagia (swallowing disorder) (4) and aphasia (disorders caused by damage to the part of the brain responsible for language control) (5). Resident #2's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 2/29/16, coded the resident's cognition as being severely impaired. Section G coded Resident #2 as requiring extensive assistance of one staff with bed mobility, transfers, dressing and personal hygiene. Section G further documented the resident required supervision and set up help with eating. A restorative progress note signed by ASM (administrative staff member) #2 (the director of nursing) on 2/5/16 documented, "Guest has a history of oral cancer, (an arrow pointing down indicating the word 'decreased' po (by mouth) intake, wt. (weight) loss, post CVA (cerebrovascular accident [stroke]) and could benefit from bed mobility and feeding programs to prevent further decline and maintain status. (Illegible word) add to RNP (restorative nursing program)." The restorative feeding program daily record documented, "Problem/Need: Unable to: (an 'x' beside) Feed self independently; Related to: (an 'x' beside) Decreased strength (and) Poor Coordination. Goals/Objectives: Guest will be able to: (an 'x' beside) Pick up utensils, Hold utensils, Chew (and) Swallow. Level of	F 311	F Tag 311 Resident #2 is receiving restorative feeding services to include cutting up her food. and supervising her meal intake. Residents receiving restorative services have the potential to be affected by this practice. The DON and ADON will in-service nursing staff on restorative nursing services to include the programs and expectation of staff to participate in programs. The DON and ADON will round daily for 4 weeks to ensure that restorative services are provided as goals are written. The DON will review weekly for 4 weeks restorative documentation to assess appropriateness and adjust programs as needed. Any variances will be corrected and continued education will be provided.	

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F 311	Continued From page 63 Assistance (an 'x' beside) Supervision, (a check beside) 6-7 days, Frequency: (a check beside) Number of Minutes Performed per Day: 15 min (minutes). Meet Goals and Objectives by: April 2016. Tier (a check beside) Functional-maintain/prevent decline in current status. Interventions: Approaches: (an 'x' beside) Verbal prompts/cues (and) hand over hand support." The percent of liquids consumed, percent of solids consumed, minutes of service (documented as 15 minutes) and staff initials were documented for breakfast and lunch for each day from 2/6/16 through 4/19/16. Resident #2's comprehensive care plan reviewed on 3/11/16 documented, "(Name of Resident #2) requires extensive assistance with ADL's (activities of daily living) related to diagnosis' of CVA with right hemiparesis and Parkinson's disease...Restorative nursing program as ordered...Unable to tolerate nutritionally adequate PO (by mouth) food and fluids resulting in need for tube feeding... Restorative feeding program as ordered..." On 4/20/16 at 8:25 a.m., Resident #2 was sitting in a wheel chair in the bedroom. The resident was served a breakfast tray that contained pancakes, bacon and oatmeal. The CNA (certified nursing assistant) serving the meal removed all lids from the resident's food and cut up the resident's food. The CNA then exited the room. Resident #2 fed herself and ate 100 percent. No staff supervision or support was provided to Resident #2 during breakfast. On 4/21/16 at 8:21 a.m., Resident #2 was sitting up in bed. The resident was served a breakfast tray that contained a biscuit covered with sausage	F 311	Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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gravy and oatmeal. The CNA removed all lids from the resident's food and placed cream and sugar in the resident's coffee. The CNA didn't cut up the resident's food before exiting the room. Resident #2 was observed removing small pieces off the top of the biscuit with a fork. At times, it took the resident three attempts to obtain a piece of biscuit on the fork prior to placing the food in her mouth. At 8:40 a.m., an activities employee entered the room and spoke to the resident about an observation through the window. At 8:41 a.m., the activities employee exited the room. At 8:42 a.m., a nurse entered the room and asked Resident #2 if she needed help. The resident shook her head side to side (indicating 'no'). The nurse offered assistance to Resident #2's roommate and exited the room. At 8:45 a.m., two CNAs entered Resident #2's room. One CNA asked the resident if she was finished. Resident #2 indicated she was finished and the CNA removed the tray from the room. Resident #2 ate 50 percent of the meal.

On 4/21/16 at 11:00 a.m., an interview was conducted with CNA #10 (a restorative CNA). CNA #10 stated the restorative department is one step below PT (physical therapy). CNA #10 stated PT works with residents for two to three weeks then the restorative department works with resident who are receiving long term care. CNA #10 stated restorative programs include: passive range of motion, active range of motion, ambulation, bed mobility, feeding and transfers. CNA #10 stated residents receive restorative programs five to seven days a week and are evaluated every quarter to determine if they still need those programs. CNA #10 was asked to describe Resident #2's restorative feeding program. CNA #10 stated Resident #2 likes to

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eat in the dining room and goes to the dining room for lunch and dinner. CNA #10 stated she goes to the dining room to cut up the resident's food and opens her milk. CNA #10 stated a nurse and another CNA are in the dining room and supervise the resident. CNA #10 stated Resident #2 doesn't have trouble eating. At this time, CNA #10 was shown Resident #2's restorative feeding program form. CNA #10 confirmed "6 to 7 days" meant the program was provided to the resident six to seven days per week. CNA #10 was asked to describe the supervision that was supposed to be provided to Resident #2. CNA #10 stated staff is monitoring the resident. CNA #10 stated the resident was independent with feeding but staff has to monitor her intake. CNA #10 stated staff has to cut Resident #10's food due to the paralysis on her right side but the resident feeds herself well. CNA #10 was shown where staff (including herself) had documented 15 minutes each day on Resident #2's restorative feeding program form. CNA #10 stated, "We are in there and I am watching her. There is always someone in the dining room watching all residents." CNA #10 was asked what occurs with Resident #2 during breakfast. CNA #10 stated Resident #2 eats breakfast in the bedroom. CNA #10 stated the resident gets boiled eggs and toast and does well. CNA #10 stated staff has to open the resident's milk, give the resident a straw, put sugar in the resident's oatmeal, salt and pepper on the resident's eggs and cut the resident's food. CNA #10 stated all CNAs and restorative CNAs are responsible for the restorative feeding programs. CNA #10 stated other CNAs perform restorative feeding programs if she does not. CNA #10 was asked if Resident #2 was monitored for 15 minutes during breakfast on this

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day. CNA #10 stated the nurse and the CNA were in the room. CNA #10 stated the nurses and CNAs know to cut up Resident #2's food and to monitor the resident.

On 4/21/16 at 11:19 a.m., an interview was conducted with CNA #9. CNA #9 was asked if CNAs participate in the restorative programs for residents. CNA #9 stated, "We don't. They (the restorative CNAs) have a list. They go around and do it (provide restorative programs). We get them (residents) dressed but don't specifically work with them."

On 4/21/16 at 11:26 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated staff other than the restorative staff does not typically participate in restorative programs unless one of the restorative employees is off.

On 4/21/16 at 2:40 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern.

The facility policy titled, "Restorative Nursing" documented, "Introduction to the Restorative Nursing Program: Policy: Restorative care is defined as a process through which our guests receive care and services that assist them to adapt and adjust to living as independently and as safely as possible. Restorative care is a dynamic process, as guests are aided in realizing their optimum physical, emotional, psychological and social potential. This process is achieved in an atmosphere that maintains our guests' dignity and self-respect, and promotes a lifestyle that is as independent and self-fulfilling as possible...Procedure: The restorative nursing

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programs are carried out under the direction of the nursing department, and are provided by licensed nurses and trained restorative aides. These programs employ measurable goals, and each guest is evaluated quarterly (or more often, if need be). Restorative programs are provided in groups of four guests or less. Nursing management will provide supervision for the restorative programs and is therefore responsible for program implementation, program utilization, documentation, review of progress, consultation with and evaluations, as needed, by therapists, and program evaluation. The nursing staff will be trained in restorative care through staff development in service programs..."

No further information was presented prior to exit.

(1) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/cancer.html

(2) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/002264.htm

(3) This information was obtained from the website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=hemiplegia

(4) This information was obtained from the website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dysphagia

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F 311	Continued From page 68 (5) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html	F 311		
F 314 SS=D	COMPLAINT DEFICIENCY 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide the necessary treatment and services to promote healing and prevent further pressure sore from developing for one of 29 residents in the survey sample, Resident #11. For Resident #11, the facility staff failed to obtain measurements of two pressure sores on the initial assessment, failed to obtain ongoing weekly wound measurements and failed to off load pressure. The findings include:	F 314	F Tag 314 Resident #11 has had measurements obtained for all applicable pressure areas identified. The measurements identified have been documented on applicable facility forms. Resident has pressure reducing surface in the wheelchair and is offered rest periods in the bed. Pressure area is resolved All residents have the potential to be affected by this practice. The licensed staff have completed an audit to ensure all areas have been identified, appropriate measurements documented and treatments are in place per physician orders.	

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F 314	Continued From page 69 Resident #11 was admitted to the facility on 3/28/16 with diagnoses that included but were not limited to: fractured right hip, respiratory failure, aspiration pneumonia, neurogenic bladder and a history of uterine cancer. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 4/4/16, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) indicating the resident was capable of making 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 eating in which she required set up assistance. In Section M - Skin Conditions, the resident was coded as having one Stage II pressure ulcer and one unstagable - deep tissue injury wound. A stage II pressure ulcer is described as partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture). May also present as an intact or open/ruptured blister. (1) A deep tissue injury if a nonblanchable purple or maroon discoloration of intact skin that may indicate damage to the underlying tissue. (2) Resident #11 was observed on 4/19/16 at 12:03 p.m. and 3:32 p.m. in her wheelchair. A resident interview was conducted with Resident #11 on 4/19/16 at 3:32 p.m. The resident stated, "My bottom is sore and has been sore since I got here. They did change the treatment today." The resident was observed on 4/20/16 at 12:49	F 314	The DON and ADON will complete education to licensed staff on wound identification, staging, measuring and treatment protocols of pressure ulcers per company policy. The Unit Managers will audit identified pressure areas weekly for 4 weeks to ensure measuring is completed and treatments are followed. Any variances will be corrected and continued education provided. The results of these audits will be reported to the DON. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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p.m. sitting in her wheelchair. The speech therapist was working with her.

Review of the "Pressure Ulcer Record" dated 3/28/16, documented, "Description - Stage II sacrum slight opened." No measurements were documented. It did documented no undermining, odor, or drainage. The color was documented as "red." Under the heading, "Length/Width/Depth in cm (centimeters) was documented, "UM (unmeasurable)." For each weekly measurements on 4/2/16, 4/8/16 and 4/15/16, a "UM" was documented under this column.

Review of the "Pressure Ulcer Record" dated, 3/28/16, documented, "Description - (L) (left) heel, soft, boggy, red, purple." The "Stage" documented, "DTI (deep tissue injury). No measurements were documented. It did document no undermining, odor or drainage and the color was documented as, "red, purple." Under the heading, "Length/Width/Depth in cm (centimeters) was documented, "UM." For each weekly measurements on 4/2/16, 4/8/16 and 4/15/16, a "UM" was documented under this column.

Review of the physician orders dated, 3/28/16, documented, "Triad Wound Dressing Paste (3); topically every shift, cleanse sacrum with wc (wound cleanser), pat dry, apply triad cream to sacrum. dx (diagnosis) preventative wound healing." Skin Prep (4) to right heel q (every) shift; dx - DTI."

The review of physician orders dated, 4/19/16, documented, "Greer's Goo (5); topically three times daily; apply Greer's goo to sacrum area q shift, effective 4/18/16 - wound healing."

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Review of the March and April TAR (treatment administration record) revealed the treatment was documented as ordered.

An observation was made of Resident #11's sacral wound and heel wound on 4/20/16 at 1:30 p.m. with the resident in bed with LPN (licensed practical nurse) #11 and LPN #12. The sacrum revealed three open areas. The areas were measured by the facility staff as: 1 x .5 cm, .5 x .5 cm, and 1.6 x .6 cm. When asked why the areas were not measured prior to today (the day of observation of the wound) LPN #11 stated, "She had so many open areas so we didn't measure them all." LPN #11 was asked how staff could tell if the wounds were healing if no measurements were being obtained. LPN #11 stated, "Well, if there are so many areas, how am I to measure them?" When asked about measuring the heel wound, LPN #11 stated, "I can only go by what I see each week on Fridays, I didn't do the initial assessment." After the observation was completed, LPN #12 asked Resident #11 if she wanted to stay off her bottom, and she stated, "Yes, that would be great." When the resident was asked if she normally takes a rest every day in bed, she stated, "No."

Resident #11 was observed on 4/21/16 at 8:16 a.m. in her wheelchair. The resident was asked if she had been offered to go back to bed in the afternoons prior to 4/20/16 to get off her bottom, Resident #11 stated, "No, the first time was yesterday (4/20/16). It's actually the first time they ever suggested I go to bed to get off my bottom."

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Review of the "Nursing Admission Assessment" dated; 3/29/16 at 1:16 a.m. did not reveal any documentation on the pressure ulcers.

The nurse's notes dated 3/28/16 through 4/19/16 were reviewed. On 3/28/16 at 3:48 p.m. it was documented, "Guest has 2 skin issues noted." There was no other documentation regarding the pressure ulcers.

Review of the comprehensive care plan dated, 4/12/16, documented, "Problems: Actual impaired skin integrity related to Sacral Wound." The "Approaches" documented in part, "Measure area weekly and document it's characteristics in the skin log. Provide assistance to reposition frequently and as needed." The care plan documented, "Problem: Potential for impaired skin integrity r/t (related to) decline in function and mobility, incontinent episodes, current skin breakdown and diagnosis." The "Approaches" documented in part, "Limit the time sitting in chair." The comprehensive care plan dated, 4/14/16 documented in part, "Problem: Actual impaired skin integrity related to heel wound." The "Approaches" documented in part, "Measure area weekly and document its characteristics."

The "Braden Scale - For Predicting Pressure Sore Risk" dated, 3/28/16, coded the resident as scoring a "16" indicating that she was at risk for developing pressure ulcers.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 4/20/16 at 1:58 p.m. When asked if a pressure ulcer, described as a Stage II should be measured, ASM #2 stated, "If it's measureable. It would depend on where it's located anatomically.

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Would have to see it to tell you that answer."

An interview was conducted with ASM #3, the regional QA (quality assurance) manager, on 4/20/16 at 2:04 p.m. When asked if a Stage II pressure area should be measured, "ASM #3 stated, "Yes." When asked if a deep tissue injury should be measured, ASM #3 stated, "I would."

The facility policy, "Pressure Ulcer Record" documented, "Policy: All pressure ulcers are to be documented on the pressure ulcer record weekly. Procedure: 4. Record the date and site when first identified. Document in the description the location and appearance of the pressure ulcer. 5. Document the wound stage. 6. Measure the wound in centimeters and record the length, width, and depth...10. The comments should address pain, drainage amount; peri wound area and progress or response to treatment....14. Continue to measure and document the wound every seven days." The facility policy, "Pressure Ulcer Identification and Treatment Protocols - Deep Tissue Injury: Purple or maroon localized area of discolored, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.....7. Evaluation wound and document. Document location, stage, length and width (cm), color, treatment and progress at least weekly and if the condition of the wound changes."

Treatment of Pressure Ulcers, U.S. Department of Health and Human Services, Publication Number 15, documents, in part on page 8: "Assessment: Assessing the Pressure Ulcer: Pressure ulcers should be uniformly described to

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facilitate communications among staff and to ensure adequate monitoring of the progress toward healing..... To monitor progress or deterioration of the lesion, the examiner must accurately measure length, width and depth of the ulcer and describe sinus tracts, tunneling, undermining, necrotic tissue, exudate and the presences or absence of granulation tissue and epithelization."

Pressure Ulcers in Adults, U.S. Department of Health and Human Services, Clinical Practice Guidelines, Publication Number 3, documents, in part on page 26: "Mechanical Loading and Support Surfaces: 8. Any individual at risk for developing a pressure ulcer should avoid uninterrupted sitting in a chair or wheelchair. The individual should be repositioned, shifting the points under pressure at least every hour or be put back to bed if consistent with overall patient goals. Rationale: The findings of researchers of the etiology of pressure ulcers indicated that prolonged, uninterrupted mechanical loading of the tissue results in breakdown of the tissue."

The administrator, ASM #1, ASM #2, the director of nursing, ASM #3, the regional QA (quality assurance) manager and ASM #4, the regional manager, were made aware of the above concern on 4/20/16 at 6:18 p.m.

No further information was provided prior to exit.

(1) This information was obtained from: Centers for Medicare & Medicaid Services; Long-Term Care Facility Resident Assessment Instrument User's Manual; Version 3.0 July 2010, pages M-15, M-18, M-2.
(2) This information was obtained from the

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F 314	Continued From page 75 website: http://www.ncbi.nlm.nih.gov/core/lw/2.0/html/tileshop_pmc/tileshop_pmc_inline.html?title=Click%20on%20image%20to%20zoom&p=PMC3&id=2697592_cia-4-269f1a.jpg. (3) Zinc-oxide-based hydrophilic paste absorbs moderate levels of wound exudates. Autolytic action softens and loosens necrotic tissue while maintaining a moist wound environment. This information was obtained from the website: http://www.woundsource.com/product/triad-hydrophilic-wound-dressing (4) Skin-Prep is a liquid film-forming dressing that forms a protective film to help reduce friction during removal of tapes and films. This information was obtained from the website: www.allegromedical.com. (5)Greer's Goo is a mixture of (nystatin, hydrocortisone, and zinc oxide). This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4456799/	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration,	F 322		

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F 322	Continued From page 76 metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		

F Tag 322

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to administer a tube feeding at the rate ordered by the physician for one of 29 residents in the survey sample, Resident #14.

The facility staff failed to administer Resident #14's tube feeding at the physician-ordered rate of 40 mls (milliliters) per hour.

The findings include:

Resident #14 was admitted to the facility on 4/7/16 with diagnoses including, but not limited to: history of a stroke, chronic obstructive pulmonary disease, Bipolar disorder, and heart disease.

The resident had not been in the facility long enough for an MDS (minimum data set) assessment to be submitted. A review of his admission nursing assessment dated 4/8/16 revealed that the resident had difficulties understanding and being understood by others. The assessment revealed that Resident #14 had a PEG (Percutaneous endoscopic gastrostomy tube*) tube in place.

Resident #14 received orders from physician services during survey for tube feeding to be at 50mls/hour.

Residents receiving tube feedings have the potential to be affected by this practice.

The DON and ADON will in-service licensed staff on guidelines for medication orders to include verbal orders.

The Unit Managers will complete an audit of all residents with orders for tube feeding to ensure they are receiving prescribed amount and rate.

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(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 322	Continued From page 77 On 4/19/16 at 2:30 p.m., Resident #14 was observed lying in his bed with the head of bed elevated. A tube feeding was being administered through the PEG tube at the rate of 50 mls/hour. Observations on 4/20/16 at 8:10 a.m. and 11:40 a.m. revealed the resident in a similar position in bed with the tube feeding at the same rate of 50 mls/hour. A review of Resident #14's clinical record revealed the following provider's order dated and signed by the nurse practitioner on 4/18/16: "Restart tube feeding [name of tube feeding product] at 40 ml/h and 300 ml water flush q 4 h (every four hours)." A review of the resident's April 2016 MAR (medication administration record) revealed no evidence of this order. The most recent entry on the MAR documented: "Enteral feeding continuous for 24 hours at 50 ml/hour." On 4/10/16 at 11:40 a.m., LPN (licensed practical nurse) #2 accompanied this surveyor to the resident's bedside. When asked to verify the rate of the tube feeding, he stated: "It's running at 50 per hour." When asked if he was aware of the rate currently ordered, he stated: "It's 50." When LPN #2 checked Resident #14's chart and saw the above-referenced order, he stated: "Uh oh. I didn't realize the order had changed. Someone didn't take the order off." He stated that he would call the physician. When asked the process for checking a tube feeding rate, he stated: "I go by the orders that are in the computer." He stated the paper order in the chart for 40 mls/hour had not been transcribed to the computer, so he did not know that the rate had changed from 50 mls/hour to 40 mls/hour.	F 322	The Unit Managers will continue to audit all new orders and admissions 5x/week for 4 weeks to ensure accuracy. Any variances will be corrected and continued education provided. The results of these audits will be reported to the DON. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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F 322	Continued From page 78 A review of Resident #14's care plan dated 4/20/16 revealed, in part, the following: "Tube feeding as ordered." On 4/20/16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional quality assurance manager, and ASM #4, the regional manager, were informed of these concerns. A review of the facility policies entitled "Use of Enteral Feeding Pumps" and "Enteral Feeding Administration" revealed nothing related to following the provider's order for the rate of administration. No further information was provided prior to exit. *PEG tube - "Percutaneous endoscopic gastrostomy tube - a tube placed in the stomach for the purpose of temporary or permanent nutrition." This information is taken from the website www.nlm.nih.gov. 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."	F 322		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections;	F 328		

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F 328	Continued From page 79 Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to store respiratory equipment in a sanitary manner for one of 29 residents in the survey sample, Resident #11. Resident #11's nebulizer treatment equipment was observed not covered or stored in a sanitary manner to prevent infection. The findings include: Resident #11 was admitted to the facility on 3/28/16 with diagnoses that included but were not limited to: fractured right hip, respiratory failure, aspiration pneumonia, neurogenic bladder and a history of uterine cancer. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 4/4/16, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) indicating the resident was capable of making daily cognitive decisions. Resident #11 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which	F 328	F Tag 328 Resident #11 has their hand held nebulizer stored in a bag, when not in use per facility policy. Residents receiving nebulizer treatments have the potential to be affected by this practice. The Unit Managers will complete rounds 5x/week for 4 weeks to ensure proper storage of nebulizer equipment. Any variances will be corrected and continued education provided. The results of the audits will be reported to the DON. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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F 328	Continued From page 80	F 328		

she required set up assistance.

On 4/19/16 at 12:03 p.m. and 3:32 p.m., Resident #11's nebulizer treatment apparatus was observed on top of the dresser, not stored in a plastic bag. The mask was just resting on the machine. The nebulizer equipment was again observed on 4/20/16 at 8:05 a.m., 12:49 p.m. and 1:30 p.m. During each observation the nebulizer equipment was not covered or stored in a plastic bag.

The physician orders dated 3/28/16, documented, "Budesonide (belongs to a class of medications called corticosteroids. It works by decreasing swelling and irritation in the airways to allow for easier breathing (1)) 0.5 MG (milligrams)/2 ML (milliliters) Susp (suspension); one half MG nebulizer twice daily."

A review of Resident #11's MAR (medication administration record) for March and April 2016 revealed documentation the medication was administered as ordered.

The comprehensive care plan dated, 4/12/16, documented, "Problems: Potential for respiratory difficulties r/t (related to) history of bronchitis and episodes of shortness of breath." The "Approaches" documented in part, "Administer medications & treatments per physician orders. Monitor for effectiveness, side effects and adverse reactions of medications and treatments and report abnormal findings to physician."

When in the room for a wound observation with LPN (licensed practical nurse) #12, on 4/20/16 at 1:30 p.m. LPN #12 was asked what was wrong with Resident #11's nebulizer mask and tubing,

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LPN #12 stated, "It's not in a bag."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 4/20/16 at 1:58 p.m. When asked where a nebulizer treatment apparatus is stored, ASM #2 stated, "At the resident's bedside." When asked how the apparatus is stored, "Bagged and dated."

An interview was conducted with ASM #3, the Regional QA (quality assurance Manager) on 4/20/16 at 2:04 p.m. When asked how a nebulizer treatment apparatus is stored, ASM #3 stated, "Stored in a bag, labeled and dated."

The facility policy, "Aerosol Treatments" documented, "13. Disassemble hand held unit, shake dry and place in bag."

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."
The administrator, ASM #2, ASM #3 and ASM #4, the regional manager, were made aware of the above findings on 4/20/16 at 6:18 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/druginfo/meds/a699056.html

F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		

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The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, the facility staff failed to ensure accurate nurse staffing was posted for two days of the survey process.

The findings include:

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F 356	Continued From page 83 On 4/19/16 at 3:30 p.m., 4:30 p.m. (with two inspectors), and at 5:00 p.m., observations of the "Report of Nursing Staff Directly Responsible for Resident Care" posted on the bulletin board to the left of the receptionist's desk in the lobby were conducted. Documented on the form was the "ACTUAL HOURS WORKED" for "7 a.m. - 3:30 p.m." There was no documentation for the next shift. On 4/20/16 at 8:20 a.m. an observation was conducted of the "Report of Nursing Staff Directly Responsible for Resident Care" form. Although the column on the form documented "ACTUAL HOURS WORKED" all three shifts were already filled in at 8:20 a.m. On 4/20/16 at 8:20 a.m., an attempt was made to interview ASM (administrative staff member) # 2, the director of nurses. ASM #2 was not in her office, but ASM # 3 the regional Quality Assurance Manager directed this surveyor to ASM # 1, the administrator. These observations were related to ASM # 1 and a request was made to speak to the staff responsible for filling out the form. The facility policy was requested at this time. During an interview on 4/20/16 at 8:40 a.m. with OSM (other staff member) # 9, the staffing coordinator, the staffing for 4/19/16 and 4/20/16 was reviewed. OSM # 9 stated that she did not work on 4/19/16 so she did not know but stated that the Director of Nurses (ASM # 2) or the assistant director of nurses fills it (Report of Nursing Staff Directly Responsible for Resident Care) out. ASM # 2 was in the room at that time and stated, "I thought I filled it out." Observations	F 356	F Tag 356 The facility has the staffing posted daily and actual hours are updated each shift, per regulations. Residents and visitors may be affected by this practice. The DON and ADON have trained the staffing coordinator on new tool to post projected and actual hours each shift daily. The 3-11 shift and 11-7 shift will be educated to update staffing posting each shift. The DON will audit the staffing sheet 5x/week for 4 weeks to ensure accuracy. The DON will report results to the NHA. Any variances will be corrected and continued education provided.	

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F 356	Continued From page 84 of 4/19/16 were shared with ASM # 2 and ASM # 2 offered nothing more. OSM # 9 was interviewed about her process of filling out the staffing report. OSM # 9 stated, she gets the Resident census and put that on (the form) then she looks at the schedule and fills out the rest of the form for the whole day. OSM # 9 stated, the next day when she comes in, she checks what staff came to work and then goes back and makes corrections in red ink. When asked where these forms are posted, OSM # 9 stated they are not posted they are all kept in my (OSM # 9's) book with the schedules. During the end of day interview on 4/20/16 at approximately 6:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM # 3, the regional Quality Assurance Manager, and ASM # 4, the Regional Manager, were informed of this concern. Review of the facility policy: "STAFFING - REQUIRED POSTING OF" "Policy: The facility will post daily for each shift the number of licensed and unlicensed nursing staff directly responsible for guest care in the facility. This information will be prominently displayed in a public area, be 8.5 X 14 inches, printed in a size/font large enough to be easily read. Posted information must include the actual number of licensed and unlicensed staff directly responsible for the care of guests for that particular day on each shift. Licensed and unlicensed nursing staff includes: registered nurses, licensed practical nurses, and nurse aides."	F 356	Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 85 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions 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 store food in a sanitary manner. A plastic bin of sugar was left opened, and a box of frozen beef patties that had been opened was unlabeled with an opened date and was not sealed, exposing the patties to the freezer environment and potential contamination. The findings include: On 4/19/16 at 12:15 p.m., an inspection of the kitchen was conducted. On the walk-through, a large plastic bin of sugar was observed uncovered. On inspection of the walk-in freezer, a box of frozen beef patties was observed opened without an opened date written on it, and was not sealed, exposing the patties to the freezer environment and potential contamination. On 4/19/16 at approximately 12:30 p.m., an interview was conducted with OSM #10 (Other Staff Member #10, the dietary manager). He stated the sugar should have been covered and	F 371	F Tag 371 The frozen beef patties were discarded during the survey, as an extra precaution. The plastic bin of sugar was emptied, cleaned and re-filled. Residents have the potential to be affected by this practice. The Dietary Manager, or designee will in service all dietary staff on storing, preparing, distributing, and serving food under sanitary conditions. The Dietary Manager will conduct audits of the refrigerator, freezer and dry storage 5x/week for 4 weeks to ensure compliance with policy. Any variances will be corrected and continued education provided. The results of the audits will be reported to the NHA.	

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F 371	Continued From page 86 the patties should have been dated and sealed. Policies were requested regarding these concerns. A review of the policy that was provided, "Receiving and Storage Safety", did not address the covering and sealing of food products. On 4/20/16 at 6:22 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey. Federal Food and Drug Code 2013 documents: 3-202.15 Package Integrity. FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants.	F 371	Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview,	F 412		

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F 412	Continued From page 87 facility document review and clinical record review, it was determined that the facility staff failed to provide dental services for two of 29 residents in the survey sample, Resident #12 and 6. 1. The facility staff failed to provide/obtain timely dental services for Resident #12, to address a cracked tooth. 2. The facility staff failed to provide timely dental services to Resident #6. The findings include: 1. Resident #12 was admitted to the facility on 12/14/13 with diagnoses that included, but were not limited to, CVA (cerebral vascular accident - a stroke), HTN (hypertension - high blood pressure), hyperlipidemia (elevated lipids in the blood stream), hemiplegia, depression, and hypercholesteremia. Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/2/16. 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. Resident #12's record documented the resident was under Medicaid services. A review of Resident #12's clinical record revealed, in part, the following physician notes:	F 412	F Tag 412 Resident #12 complained of tooth pain during the survey. Resident #12 had received dental services prior and an appointment was made following the survey. However, resident refused and stated his pain was resolved. Resident will receive services in the future as needed. Resident #6 had dental services prior to survey and will be offered services as needed in the future. Residents needing dental services have the potential to be affected by this practice. An audit will be completed on residents to identify if they have a need for dental services that have not been addressed.	

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F 412	Continued From page 88 "12/2/15. Pt. (patient) requests visit today r/t (related to) right tooth "ache" x 2 days. Assessment and Plan: cracked tooth, acute. Nursing to schedule Dentist appointment." "1/18//16. Interval history: Reports mouth toothache pain. Nurse spoke to pt's (patient's) son regarding dental appt (appointment). Awaiting son to make dental appt. Assessment and plan: Toothache R (right) anterior- ongoing- Staff to schedule dental appointment asap (as soon as possible) after checking with family re: preferred provider." Further review of Resident #12's clinical record did not reveal any nursing notes or social service notes that evidenced that Resident #12 had received dental services. A review of nursing notes for Resident #12 revealed, in part, that Resident #12 had received pain medication for documented toothache on the following dates: 12/10/15; 12/16/15; 12/26/15; 1/25/16; 3/21/16; 3/23/16; 3/24/16; 3/25/16; 3/26/16; 3/27/16; 4/18/16 and 4/19/16. On 4/20/16 at 10:00 a.m. an interview was conducted with Resident #12. Resident #12 was asked whether or not he had seen a dentist. Resident #12 stated that he had seen one on 2/10/16 because of toothache. Resident #12 was asked whether or not he continued to have problems with the tooth, Resident #12 stated that he was supposed to go back and have the tooth surgically extracted. Resident #12 stated that the tooth had broken and the dentist couldn't just pull the tooth. Resident #12 was asked whether or not he continued to have problems with the tooth. Resident #12 stated that it hadn't bothered him too much.	F 412	The NHA will in- service social services staff on providing medically – related services to attain or maintain the highest practicable physical, well- being. The Social Services Director will audit residents with need for services weekly for 4 weeks to ensure timely appointments are made to maintain well- being. Results will be reported to the NHA. Any variances will be corrected and continued education provided. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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On 4/20/16 at 11:40 a.m. an interview was conducted with RN (registered nurse) #4, the unit manager. RN #4 was asked whether or not there was a consult request for Resident #12. RN #4 stated that she did not know. RN #4 was asked whether or not Resident #12 had seen a dentist. RN #4 stated that she thought he had seen a dentist. RN #4 was asked when Resident #12 saw a dentist and to provide the documentation of the dental visit. RN #4 was unable to locate any documentation and stated, "If the resident didn't bring anything back from the visit we wouldn't have anything." RN #4 was asked what the responsibility of the nursing staff was to determine the plan of care for a resident who had been on a consult visit. RN #4 stated, "We should have called to follow up." RN #4 requested more time to gather information.

On 4/20/16 at 12:45 p.m. RN #4 stated that she had called the dentist and that he had "no recommendations". RN #4 was asked to provide a consult sheet or note from the dentist that would evidence no further care required. RN #4 stated she did not have it but would try. RN #4 was asked who was responsible for resident care, RN #4 responded; "Nurses on the unit make sure that the medications and treatments are provided and that ADL (activities of daily living) are done. Nurses are also responsible to make sure that physician orders are followed and that the resident sees the physician when necessary." RN #4 was asked what is documented when a resident leaves the facility for a consult. RN #4 responded, "The night shift nurse gets the paperwork ready for the appointment and generally the nurses document when the resident leaves the facility. We did not document anything

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when (name of Resident #12) when to see the dentist." RN #4 was asked what other documentation would be included when a resident goes out of the facility on an appointment. RN #4 responded, "There should be documentation when they return, we would document the time of return and whether or not there are any new orders." RN #4 was asked whether or not this was done for Resident #12, RN #4 stated it was not done. RN #4 was asked whether or not Resident #12 needed to go back to the dentist, RN #4 responded that she did not know.

On 4/20/16 at 1:00 p.m. an interview was conducted with LPN (licensed practical nurse) #10. LPN #10 stated that she worked with Resident #12 the day following his dental appointment and that he (Resident #12) had told her that he needed an extraction. LPN #10 was asked whether or not she documented anything or followed up with the dentist that Resident #12 had seen. LPN #10 responded that she had talked to his (Resident #12's) son about getting another appointment. LPN #10 was asked whether or not she followed up and she stated that she did not. LPN #10 was asked what she should have done to ensure that Resident #12 received the necessary treatment. LPN #10 stated that she should have followed up or involved social services to get Resident #12 the treatment he needed.

A review of Resident #12's care plan dated 9/1/15 and reviewed on 3/9/16 revealed, in part, the following documentation: "Onset/DC (discontinued) 12/28/15. Problems/Conclusions: Pain: Actual Pain related to cracked tooth. Approaches/Interventions: Administer

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medications for pain and observe for effectiveness (sig)/side effects and report ineffectiveness to physician."

~~At an end of the day meeting on 4/20/16 at 5:50~~ p.m., ASM (administrative staff member) #1, the facility administrator; ASM #2, the director of nursing; ASM #3, the regional QA (quality assurance manager) and ASM #4, the regional manager; were made aware of the above findings. ASM #1 stated that she would look for information to determine whether or not anything was documented about Resident #12's dental appointment. A policy was requested at this time for consult appointments.

On 4/20/16 at 8:40 a.m. ASM #1 was interviewed. ASM #1 stated, "We are still trying to get documentation on the dental appointment. We know that nothing is documented and we know that follow up was not done."

On 4/21/16 at 9:05 a.m. an interview was conducted with OSM (other staff member) #2, the social worker. OSM #2 was asked what her role was in regards to dental appointments. OSM #2 responded that she did not get involved with dental appointments unless there was a problem. OSM #2 was asked about Resident #2. OSM #2 responded, "I had no idea about his dental issues. He never mentioned dental issues to me."

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

2. The facility staff failed to provide/obtain timely dental services for Resident #6.

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Resident #6 was admitted to the facility on 5/7/11 with diagnoses including, but not limited to: Bipolar disorder, seizure disorder, Schizophrenia, dementia, heart disease, and depression. On the most recent MDS (minimum data set), a significant change assessment with ARD (assessment reference date) 2/10/16, she was coded as having moderate cognitive impairment for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was coded as having broken teeth.

On 4/20/16 at 8:10 a.m., Resident #6 was observed sitting up in bed in her room. When the resident smiled, the surveyor observed that she had multiple chipped/broken/missing teeth. An attempt to interview the resident about her dental status was unsuccessful due to Resident #6's nonsensical responses.

A review of Resident #6's clinical record revealed a nurse's note written 11/12/15 by LPN (licensed practical nurse) #1. The note stated, in part: "Guest commented that she eats all of her food but that she only has one tooth. RD (registered dietician) made aware and diet downgraded to mechanical soft."

Further review revealed the following note written by OSM (other staff member) #1, the registered dietician, on 12/2/15: "Diet has been liberalized from Heart Healthy and texture has been changed to mechanical soft due to poor dentition."

Further review revealed the following note written by the nurse practitioner on 12/11/15: "[Resident #6] states difficulty chewing, no difficulty swallowing. Ordered dental consult." The record

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review revealed no evidence that the nurse practitioner actually ordered the consult, and attempts to interview the nurse practitioner during the survey were unsuccessful.

Further review revealed the following note written on 2/9/16 by OSM #2, the social worker: "Guest (sic) family is looking to have residents (sic) teeth looked at. Guest has Medicaid and I provided a number to the unit manager for [name of local dentist] to call and make an appointment."

A review of Resident #6's weights revealed, in part, the following: 11/5/15 - 157.4; 12/1/15 - 156.4; 1/4/16 - 155.8; 2/7/16 - 143; 3/1/16 - 146.8; 4/4/16 - 147. The review revealed multiple interventions by the facility staff to address Resident #6's weight loss, including double portions of meals and dietary supplements.

A review of the clinical record revealed the following note written by the nurse practitioner on 3/18/16: "Weight loss over several months due to self-restricting diet to fruit and cottage cheese due to dental issues. Brother took her to DDS (dentist) 3/16/16 and she had #7 and #26 extracted."

A review of the comprehensive care plan for Resident #6 dated 2/22/16 revealed, in part, the following: "Alteration in dental status related to: some of natural teeth missing, broken/loose/carious teeth....Dental consults as needed."

On 4/20/16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional quality assurance manager, and ASM #4, the regional

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manager, were informed of these concerns.

On 4/21/16 at 8:35 a.m., OSM #2 was interviewed regarding the process for obtaining dental consults for residents. She stated: "I don't really get involved in that. If someone needs a phone number or something, I will get them the number. The nurses do the calling and set the appointments." When shown the above referenced note (2/9/16) and asked what she remembered about Resident #6's dental situation, she stated: "The guest's son contacted me to let me know." She stated that she thought it was the son's job to make the appointment for the resident. She stated: "I gave the son the number." When asked if she followed up to see if the son made the appointment in a timely manner, she stated, "No I didn't. I assumed he would make the call. I gave him the number of a dentist who takes Medicaid and that's the last I heard of it." When asked if she was aware that Resident #6 had been losing weight since November 2015, she stated: "Sometimes I went to the care plan meetings. But now I don't much anymore." She stated she did not have a memory of the weight loss coming up in any discussions with other staff members. When asked to review her note again and to explain the discrepancy between what she had just told the surveyor (that she gave the resident's son the phone number) and what her note stated (that she gave the phone number to the unit manager [LPN #1], she stated: "Oh. Well, maybe it was the unit manager who asked for the number. I'm assuming that I talked to the unit manager, not the son." When asked if she specifically remembered a conversation with the resident's son about the resident's dental needs, she stated: "Now that you mention it, not really. [LPN #1]

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probably brought it up in an evening meeting."

On 4/21/16 at 8:45 a.m., LPN #1 was interviewed regarding the process for obtaining dental services for residents. She stated: "We don't have a dentist who comes here." She stated that she becomes aware of needs for dental services from residents themselves or from families. She stated: "Most of our residents are on Medicaid. The nurses are responsible for calling the dentists and setting up transportation." When shown the progress note from the nurse practitioner dated 12/11/15, she stated: "This is the first time I'm seeing this. It's just a note. I don't see an order." When asked what she remembered about Resident #6's dental consult resulting in tooth extraction on 3/16/16, she stated: "I can't tell you. We don't keep the paperwork. I don't know when the appointment was actually made." She stated she would "do some checking" and let the surveyor know what she found out. On 4/21/16 at 11:05 a.m., she stated: "I don't have any notes or any information. I don't know why it took so long for us to get her a dental consult."

On 4/21/16 at 11:10 a.m., OSM #1 was interviewed regarding Resident #6's dental status. She stated: "We have been following [the resident] for some time." She stated she did not recall anyone telling her that the resident was having trouble chewing due to poor dentition. She stated that she had not actually assessed the resident face-to-face. When asked about the physician's comment about the resident self-restricting her diet due to dental issues, she stated: "I was not thinking this was related to her dentition. I thought she just preferred those foods for some reason."

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F 412	Continued From page 96 A review of the facility policy entitled "Dental Services" revealed, in part, the following: "The facility will provide or obtain from an outside resource, routine and twenty-four (24) hour emergency dental services to meet the needs of each guest...If necessary, the facility must assist the guest in making appointments, arranging transportation to and from the dentist's office, and promptly referring guests with lost or damaged dentures to a dentist." No further information was provided prior to exit.	F 412		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		

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F 441	Continued From page 97 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to store respiratory equipment in a manner to prevent infection for one of 29 residents in the survey sample, Resident #11. The Resident #11's nebulizer treatment equipment was observed not covered or stored in a manner to prevent infection. The findings include: Resident #11 was admitted to the facility on 3/28/16 with diagnoses that included but were not limited to: fractured right hip, respiratory failure, aspiration pneumonia, neurogenic bladder and a history of uterine cancer. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 4/4/16, coded the	F 441	F Tag 441 Resident #11 has their hand held nebulizer stored in a bag when not in use per facility policy. Residents receiving nebulizer treatments have the potential to be affected by this practice. The Unit Managers will complete rounds 5x/week for 4 weeks to ensure proper storage of nebulizer equipment. Any variances will be corrected and continued education provided. The results of the audits will be reported to the DON.	

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F 441	Continued From page 98 resident as scoring a 14 on the BIMS (brief interview for mental status) indicating the resident was capable of making daily cognitive decisions. Resident #11 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required set up assistance. On 4/19/16 at 12:03 p.m. and 3:32 p.m., Resident #11's nebulizer treatment apparatus was observed on top of the dresser, not stored in a plastic bag. The mask was just resting on the machine. The nebulizer equipment was again observed on 4/20/16 at 8:05 a.m., 12:49 p.m. and 1:30 p.m. During each observation the nebulizer equipment was not covered or stored in a plastic bag. The physician orders dated 3/28/16, documented, "Budesonide (belongs to a class of medications called corticosteroids. It works by decreasing swelling and irritation in the airways to allow for easier breathing (1)) 0.5 MG (milligrams)/2 ML (milliliters) Susp (suspension); one half MG nebulizer twice daily." A review of Resident #11's MAR (medication administration record) for March and April 2016 revealed documentation the medication was administered as ordered. The comprehensive care plan dated, 4/12/16, documented, "Problems: Potential for respiratory difficulties r/t (related to) history of bronchitis and episodes of shortness of breath." The "Approaches" documented in part, "Administer medications & treatments per physician orders. Monitor for effectiveness, side effects and adverse reactions of medications and treatments	F 441	The DON and ADON will complete in servicing to licensed staff on proper storage for nebulizer equipment to ensure sanitation and infection control. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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and report abnormal findings to physician."

When in the room for a wound observation with LPN (licensed practical nurse) #12, on 4/20/16 at 1:30 p.m. LPN #12 was asked what was wrong with Resident #11's nebulizer mask and tubing, LPN #12 stated, "It's not in a bag."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 4/20/16 at 1:58 p.m. When asked where a nebulizer treatment apparatus is stored, ASM #2 stated, "At the resident's bedside." When asked how the apparatus is stored, "Bagged and dated."

An interview was conducted with ASM #3, the Regional QA (quality assurance Manager) on 4/20/16 at 2:04 p.m. When asked how a nebulizer treatment apparatus is stored, ASM #3 stated, "Stored in a bag, labeled and dated."

The facility policy, "Aerosol Treatments" documented, "13. Disassemble hand held unit, shake dry and place in bag."

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."
The administrator, ASM #2, ASM #3 and ASM #4, the regional manager, were made aware of the above findings on 4/20/16 at 6:18 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the website:

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(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 441	Continued From page 100 https://www.nlm.nih.gov/medlineplus/druginfo/meds/a699056.html	F 441		
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT	F 500		

If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section.

Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and in the course of complaint investigation, it was determined that the facility staff failed to maintain a contractual agreement for dental services.

The findings include:

Review of the facility's state department of health application for nursing home license completed by ASM (administrative staff member) #1 (the facility administrator) on 10/12/15 revealed the name of the facility's dental consultant.

F Tag 500

A contract has been established for routine and emergency dental services to meet the needs of each guest.

Residents with dental needs have the potential to be affected.

The Social Services Director will audit residents with need for services weekly for 4 weeks to ensure timely appointments are made to maintain well- being. Results will be reported to the NHA. Any variances will be corrected and continued education provided.

NHA will provide education to social services department on coordination of dental services and contractual arrangements.

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	495109	A. BUILDING _____ B. WING _____	C 04/21/2016

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F 500	Continued From page 101 On 4/19/16 at approximately 11:45 a.m. during the entrance conference, ASM #1 was asked to provide all contracts for outside services. On 4/20/16 at approximately 10:35 a.m., ASM #1 was asked to provide all facility dental contracts. On 4/20/16 at 11:07 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated no dentist comes to the facility. LPN #1 stated residents only go out to a dentist as needed and it's hard to find a dentist that accepts Medicaid residents. On 4/20/16 at 2:15 p.m., ASM #1 stated the dentist documented on the nursing home license application no longer provided services for the facility. ASM #1 stated the facility didn't have a dental contract with any particular dentist and the facility just refers residents out to dentists. ASM #1 stated she would provide a list of dentists used by the facility. The list provided by ASM #1 documented the name of two dentists. On 4/21/16 at 2:25 p.m., ASM #1 was made aware the above findings were a concern. ASM #1 stated it was becoming hard to find dentists who would agree to a contract. ASM #1 stated there was one group of dentists but they wouldn't accept Medicaid residents. No further information was presented prior to exit.	F 500	Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	
F 502 SS=D	COMPLAINT DEFICIENCY 483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The	F 502		

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F 502	Continued From page 102 facility is responsible for the quality and timeliness of the services. 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 obtain physician ordered laboratory tests for one of 29 residents in the survey sample, Resident #2. The facility staff failed to obtain Resident #2's laboratory (lab) tests ordered by the physician on 2/11/16 and 4/11/16. The findings include: Resident #2 was admitted to the facility on 4/9/99. Resident #2's diagnoses included but were not limited to: malignant neoplasm (cancer) (1) of cheek mucosa (tissue) (2), hemiplegia (paralysis) (3), dysphagia (swallowing disorder) (4) and aphasia (disorders caused by damage to the part of the brain responsible for language control) (5). Resident #2's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 2/29/16, coded the resident's cognition as being severely impaired. Section G coded Resident #2 as requiring extensive assistance of one staff with bed mobility, transfers, dressing and personal hygiene. Section G further documented the resident required supervision and set up help with eating. A physician's order dated 2/11/16 documented an order for a CBC (complete blood count) (6) and	F 502	F Tag 502 Resident #2's physician was notified of missing labs, new order received from physician and labs obtained. Resident # 2 received no harm as a result of this practice. All residents with orders to obtain labs have the potential to be affected by this practice. The Unit Managers will complete an audit of orders for labs to ensure physician orders have been followed. Any variances will be corrected, physician notification will be made as indicated and additional education will be provided. The DON and ADON will in-service licensed staff on obtaining labs for residents per physician orders in a timely manner to ensure quality of care.	

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F 502	Continued From page 103 CMP (comprehensive metabolic panel) (7) with the next blood draw. A physician's progress note, dated 2/11/16 documented a rash on the resident's left arm but failed to document the specific reason for the ordered laboratory tests. A physician's order dated 4/11/16 documented an order for a CBC and CMP with the next blood draw. A physician's progress note dated 4/11/16 documented in part, "Follow up labs next blood draw. Not done as ordered 2/16..." Review of Resident #2's clinical record failed to reveal laboratory test results for a CBC or CMP during February 2016 or April 2016. Resident #2's comprehensive care dated 3/11/16 documented, "Unable to tolerate nutritionally adequate PO (by mouth) food and fluids resulting in need for tube feeding...4/20/16- Labs as ordered, Report abnormals to MD (medical doctor)..." On 4/20/16 at 12:58 p.m., LPN (licensed practical nurse) #1 confirmed the above requested labs were not obtained. LPN #1 was asked the facility process for obtaining physician ordered labs. LPN #1 stated nurses are supposed to transcribe the order into the computer system and the lab log. LPN #1 stated the 2/11/16 order for labs was "taken off" (signed by a nurse) but not transcribed into the computer system or lab log. LPN #1 stated the physician wrote the 4/11/16 lab order and she (LPN #1) didn't know if the order was "taken off." On 4/20/16 at approximately 6:00 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of	F 502	The Unit Managers will audit new admissions and new orders 5x/week for 4 weeks to ensure physician orders are followed timely. Any variances will be corrected and physician notification is made along with continued education. The results of the audits will be reported to the DON. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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F 502	Continued From page 104	F 502		

nursing) were made aware of the above findings.

The facility policy titled, "Lab Scheduling and Tracking Log" documented, "Policy: The facility will use the Lab Scheduling and Tracking Log or an automated tracking format to ensure that the facility is maintaining a system for tracking lab test collection and physician notification...Procedure: 1. The Lab Scheduling and Tracking Log will be placed in the front of the lab notebook. 2. The charge nurse (usually the night nurse) records on the form each lab that is to be collected. The nurse will record the date, guest's name, and test to be done. 3. The charge nurse (usually the night nurse) should validate daily the completed lab request forms with the lab calendar to ensure that all labs required for that day have completed lab requisitions. 4. The lab tech (or the nurse collecting the specimen) will initial on the log that the specimen was collected for that guest on the date indicated. 5. The nurse receiving the results of the test will initial that the test results were received. 6. The nurse will notify the physician of the test results and document the date the physician was notified and initial on the lab report. The nurse will also document physician notification and physician's response in the Progress notes."

No further information was presented prior to exit.

(1) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/cancer.html

(2) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/002264.htm

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F 502	Continued From page 105 (3) This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=hemiplegia (4) This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dysphagia (5) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html (6) A CBC measures different components in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/003642.htm (7) A CMP measures different chemicals in the blood. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=cmp	F 502		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician.	F 504		

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F 504	Continued From page 106 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 obtain a physician order prior to performing a laboratory test for one of 29 residents in the survey sample, Resident #3. The facility staff obtained a CMP (comprehensive metobolic panel (1)), Lipid panel (2), CBC (complete blood count (3)), TSH (thyroid-stimulating hormone (4)) and uric acid (5) blood work without a physician's order for Resident #3. The findings include: Resident #3 was admitted to the facility on 5/4/98 with a readmission on 9/24/12 with diagnoses that included but were not limited to: multiple sclerosis (a nervous system disease that affects the brain and spinal cord (6)), osteoarthritis, gout, paralysis, high blood pressure, obesity, neurogenic bladder, edema, and seizure disorder. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/12/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one staff member for all of his activities of daily living except eating and moving on the unit (the resident had motorized wheelchair). Review of the clinical record revealed a laboratory test result dated, 12/10/15. The report documented the results of a CMP, lipid panel, CBC, TSH and uric acid.	F 504	F Tag 504 Resident #3's physician was notified that labs were obtained. Residents requiring labs to be obtained have the potential to be affected. The Unit Managers will complete an audit of orders for labs to ensure physician orders have been followed. Any variances will be corrected, physician notification will be made as indicated and additional education will be provided. The DON and ADON in-serviced licensed staff on obtaining a physician order prior to obtaining labs and following the orders timely to ensure quality of care.	

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F 504	Continued From page 107 Review of the physician orders did not reveal a physician order for the above laboratory tests. A copy of the physician order was requested from LPN (licensed practical nurse) #1on 4/20/16 at 11:50 a.m. A copy of the physician order was requested from the administrator on 4/20/16. At the end of the day meeting on 4/20/16 at 6:18 p.m. a copy of the physician order was requested from the administrative team. On 4/21/16 at 8:00 a.m. a yellow sticky note was received that documented, "No lab (laboratory) order for (Resident #3)." An interview was conducted with LPN (licensed practical nurse) #12 on 4/21/16 at 8:25 a.m. When asked the process for obtaining laboratory tests, LPN #12 stated, "First you have to have a physician's order. We put the order in the computer. The lab (laboratory) comes and draws it when scheduled." LPN #12 was asked if a physician's order was required to obtain laboratory tests. LPN #12 stated, "Yes, must have an order from a physician." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 4/21/16 at 8:28 a.m. When asked the process for obtaining laboratory (lab) tests, ASM #2 stated, "First a physician order is required. Then we fill in the requisition slip. The lab is here Monday through Friday." The facility policy, "Lab Scheduling and Tracking Log," did not address having a physician order for laboratory tests.	F 504	The Unit Managers will audit new admissions and new orders 5x/week for 4 weeks to ensure physician orders are followed timely. Any variances will be corrected and physician notification is made along with continued education. The results of the audits will be reported to the DON. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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F 504	Continued From page 108 The administrator was made aware of the above findings on 4/21/16 at 12:15 p.m.	F 504		

(1) A CMP (comprehensive metabolic panel) A metabolic panel is a group of tests that measures different chemicals in the blood. These tests are usually done on the fluid (plasma) part of blood. The tests provide information about your body's chemical balance and metabolism. They can give doctors information about your muscles (including the heart), bones, and organs, such as the kidneys and liver. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/metabolicpanel.html.
(2) The lipid profile is used as part of a cardiac risk assessment to help determine an individual's risk of heart disease and to help make decisions about what treatment may be best if there is borderline or high risk. This information was obtained from the website: https://labtestsonline.org/understanding/analytes/lipid/tab/test
(3) A complete blood count (CBC) test measures the following: The number of red blood cells. The number of white blood cells. The total amount of hemoglobin in the blood. The fraction of the blood composed of red blood cells hematocrit. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/003642.htm
(4) The thyroid-stimulating hormone (TSH) test is often the test of choice for evaluating thyroid function and/or symptoms of a thyroid disorder including hyperthyroidism or hypothyroidism. This information was obtained from the website: https://labtestsonline.org/understanding/analytes/tsh/tab/test.
(5) The uric acid blood test is used to detect high

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F 504	Continued From page 109 levels of this compound in the blood in order to help diagnose gout. This information was obtained from the website: https://labtestsonline.org/understanding/analytes/uric-acid/tab/test. (6) This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=MS	F 504		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on resident interview, 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 three of 29 residents in the survey sample, Resident #1, 9 and 25. 1 a. A review of Resident #1's clinical record	F 514	F Tag 514 Resident #1's order for a fleece pad was discontinued during the survey. Resident #25 has discharged from the facility. Resident #9 did not receive the flu vaccine. There has been no harm as a result of this practice. All residents have the potential to be affected by this practice.	

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F 514	Continued From page 110 revealed that medications were administered to Resident #1 and not documented as administered. b. Resident #1 was observed over two days not wearing a fleece pad on her right elbow as ordered by the physician while she was up in her wheelchair. The documentation indicated that the fleece pad was on her right elbow as ordered. 2. Facility staff failed to document the administration of the flu vaccination for the 2015 through 2016 flu season in Resident #9's clinical record. 3. The facility staff failed to document in the clinical record that Resident #25 was transferred to the hospital. The findings include: 1a. Resident #1 was admitted to the facility on 6/10/15 with diagnoses that included, but were not limited to, CVA (cerebral vascular accident - a stroke), HTN (hypertension - high blood pressure), obesity, hyperlipidemia (elevated lipids in the blood stream), diabetes, sleep apnea and expressive aphasia (difficulty speaking). Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/10/16. Resident #1 was coded on the MDS as having a BIMs (Brief Interview for Mental Status) score of 7 out of 15. The MDS manual documents that a score of 7 indicates that the resident's cognition is severely impaired.	F 514	The DON and ADON will complete in-servicing to licensed staff on maintaining clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The Unit Managers will complete an audit 5x/week for 4 weeks of all new orders and new admission orders for devices to ensure they are documented, new admission medication orders along with new medication orders are documented on the MAR. The Unit Managers will also audit discharge records 5x/week for 4 weeks for clinical documentation to ensure discharges have orders and nurses notes timely. Any variances identified will be corrected and continued education provided. The	

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F 514	Continued From page 111 A review of Resident #1's medication administration records (MARs) for April 2016 and March 2016 revealed, in part, that medications were not consistently signed by a nurse as being administered. The following medications were not documented as being given to Resident #1; Oxycodone/acetaminophen 5/325 * (used to treat pain) was not documented as administered on 3/4/16 at 6:00 a.m.; 3/16/16 at 2:00 p.m.; 3/24/16 at 10:00 a.m. and 2:00 p.m.; 3/29/16 at 10:00 a.m. and 2:00 p.m. and 3/30/16 at 10:00 a.m. Humalog ** (a type of insulin used to treat high blood sugar levels) was not documented as administered on 3/29/16 at 7:30 a.m. Lidocaine Patch *** (used to treat pain) was not documented as administered on; 3/25/16 at 10:a.m.; 3/29/16 at 10:00 a.m. and 3/30/16 at 10:00 a.m. Baclofen**** (used to treat nerve pain) was not documented as administered on: 3/16/16 at 2:00 p.m.; 3/24/16 at 2:00 p.m.; 3/29/16 at 2:00 p.m. and 4/19/16 at 2:00 p.m. Famotidine ***** (used to treat stomach ulcers and acid reflux) was not documented as administered on: 3/4/16 at 6:30 a.m.; 3/18/16 at 6:30 a.m. and 3/24/16 at 6:30 a.m. Further review of Resident #1's clinical record did not reveal any nursing notes on the back of the MAR or in the progress notes that would explain medications not being administered. At an end of the day meeting on 4/20/16 at 5:50 p.m., ASM (administrative staff member) #1, the facility administrator; ASM #2, the director of nursing; ASM #3, the regional QA (quality assurance manager) and ASM #4, the regional manager; were made aware that there were a	F 514	results of these audits will be reported to the DON. Continued compliance will be monitored through random chart audits by the DON and reported to the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: May 26, 2016	

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number of medications that were not documented as administered to Resident #1. ASM #1 was asked to arrange a meeting with several of the nursing staff the next morning.

On 4/21/16 at 8:00 a.m. an interview was conducted with LPN (licensed practical nurse) #15. LPN #15 was asked to describe her process when administering a medication. LPN #15 described that she would withdraw the medications that were to be administered to the resident and compare to the MAR on her computer. When asked what was documented, LPN #15 stated that all meds (mediations) that are administered are checked as being administered. LPN #15 was asked under what circumstances an administration time for a medication would be left blank. LPN #15 responded, "If the medication was not given because the resident refused or something like that, then we would place a note for that time. You have to put something in the box or it (the computer) will keep asking." LPN #15 was shown where sometimes on Resident #1's MAR; nothing was checked for a medication. LPN #15 reviewed Resident #1's MAR and stated, "I know I gave the medications I don't know how I missed not documenting them."

On 4/21/16 at 8:40 a.m. an interview was conducted with LPN #3. LPN #3 described her process for giving medications as pulling up the MAR and comparing to the medications in the package. When asked about documentation of the medications following administration, LPN #3 stated that she would document on the MAR. When asked what would cause a blank space on the MAR LPN #3 stated, "Then the medication was not "clicked" as administered" LPN #3 was

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shown the dates and times where medications were not "clicked" as administered for Resident #1. LPN #3 reviewed the dates and times and stated that she had no idea why the spaces were blank, that she remembered giving the medications. LPN #3 further stated, "Sometimes the computer won't show medications as missed until after 3:00p.m., after I am gone. I don't really know but it could be an issue with the computer."

A review of the facility policy titled "Medication Administration" revealed, in part, the following documentation. "Procedure: 10. Initial the guest's Medication Administration Record (MAR) immediately following administration. 11. Record any medication omissions including date, time and reason on the back of the Medication Administration Record (MAR)."

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

*This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=17971

**This information was obtained from the following website: http://www.humalog.com/about-mealtime-insulin.aspx

***This information was obtained from the following website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a603026.html

****This information was obtained from the following website:

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https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682530.html

*****This information was obtained from the following website:
https://www.nlm.nih.gov/medlineplus/druginfo/meds/a687011.html

b. Resident #1 was observed over two days not wearing a fleece pad on her right elbow as ordered by the physician while she was up in her wheelchair. The documentation indicated that the fleece pad was on her right elbow as ordered.

A review of Resident #1's clinical record revealed a care plan dated 6/18/15 documenting, in part, the following entry:
"Onset: 7/7/15. Problems/Conclusions: Skin: Potential for impaired skin integrity related to decreased ADL (activities of daily living) ability, incontinence, decreased mobility. Measurable Goals: Skin will remain intact for next 90 days. Goal LT (long term): Reviewed 5/24/16. Approaches/Interventions: Use fleece elbow protector to R (right) elbow. Start 7/7/15."

Resident #1 was observed on the following dates and times sitting in her wheelchair with a lap tray to rest her right arm on and there was no fleece protector on her right elbow: 4/19/16 at 4:00 p.m.; 4/20/16 at 11:25 a.m.; 4/20/16 at 4:30 p.m.

Further review of Resident #1's clinical record revealed a POS (physician order sheet) documenting, in part, "active orders (4/1/16 - 4/30/16)." The following order was documented: "Start: 2/1/16 End 6/18//17. Active Recertified

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3/31/16. Treatment: fleecee (sig) protector to right elbow q (every) shift while in wc (wheelchair) every shift every shift (sic) (day, eve (evening), night). Telephone order from (name of physician) taken by (name of nurse)."

A review of Resident #1's TARs (treatment administration record) for the month of April 2016 revealed, in part, the following treatment; "Treatment every shift for Start: 2/1/16 3:57 am (morning). DC (discontinue) 4/20/16 04:54 pm (evening). Extended Directions: fleecee (sig) protector to right elbow q shift while in wc every shift." On 4/19/16 a nurse initialed that the fleece protector was on Resident #1's right elbow on day shift, evening shift and night shift. On 4/20/16 a nurse initialed that the fleece protector was on Resident #1's right elbow on dayshift.

On 4/20/16 at 4:45 p.m. an interview was conducted with LPN (licensed practical nurse) #16. LPN #16 was asked who was caring for Resident #1 on that day. LPN #16 responded that she was caring for Resident #1. LPN #16 was asked whether or not she was aware of any special equipment that Resident #1 was to have each day. LPN #16 referred to her computer system and stated, "(Resident #1) has an order for a fleece elbow protector to be placed on her right elbow." LPN #16 was asked who was responsible for checking that the fleece elbow pad was in place. LPN #16 responded that everyone was responsible. LPN #16 was asked whether or not the fleece elbow pad was checked off today as being on Resident #1. LPN #16 responded, "It is." LPN #16 was asked whether or not she had noticed it being on Resident #1, LPN #16 responded that she had just checked Resident #1's blood sugar but hadn't noticed

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whether or not the fleece elbow pad was or wasn't on. LPN #16 added, "It is supposed to be on." At this time LPN #16 accompanied this surveyor to look at Resident #1 who was sitting in her wheelchair in the dining room. Resident #1 was not wearing the fleece elbow pad to her right elbow. LPN #16 spoke with Resident #1 then stated, "(Resident #1) does not want it on, it should be discontinued." LPN #16 stated that she would contact the physician and get it discontinued since the resident was refusing to wear it. LPN #16 was asked why it was documented on the TAR that it was on the resident. LPN #16 stated, "it should not be documented as on if it is not being placed on her arm."

A review of the facility policy titled " Interdisciplinary Care Plan " revealed, in part, the following documentation: "2. The interdisciplinary care plan will: e. Identify the professional services that are responsible for each element of care and frequency of services provided."

At an end of the day meeting on 4/20/16 at 5:50 p.m., ASM (administrative staff member) #1, the facility administrator; ASM #2, the director of nursing; ASM #3, the regional QA (quality assurance manager) and ASM #4, the regional manager; were made aware of the above findings. No further information was provided prior to the end of the survey.

2. Facility staff failed to document the administration of the flu vaccination for the 2015 through 2016 flu season in Resident #9's clinical record.

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Resident #9 was admitted to the facility on 11/21/14 with diagnoses that included but were not limited to neurosyphillis,* major depressive disorder, altered mental status, chronic pain, and dementia.

Resident #9's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/21/16. Resident #9 was coded as being able to understand others for communication and being understood by others for communication. Resident #9 was coded as requiring supervision with transfers, dressing, locomotion, and ambulation; extensive assistance from staff with toileting, personal hygiene and bathing; and independent with meals.

Review of the clinical record revealed that Resident #9's RP (responsible party) had consented to receive the flu vaccination annually. Her signature was dated "1/26/14."

Review of Resident #9's POS (Physician Order Sheet) dated 4/21/16 revealed an active order initiated on 2/28/15 that documented the following: "flu vaccine: inject 0.5 ml (milliliters) i.m. (intramuscular) once a year x 1 dose, October through march, if resident is not allergic."

Further review of the clinical record revealed an immunization record. The immunization record under section "Influenza Vaccination," was blank.

Review of the MARS (Medication Administration Record) from 10/1/15 to 4/21/16 revealed no evidence that the flu vaccination was given.

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F 514	Continued From page 118 On 4/20/16 at 5:30 p.m., an interview was conducted with LPN (Licensed practical nurse) #1, the unit manager. When asked who was responsible for tracking the flu vaccine she stated that the unit managers were responsible. She stated that when a resident receives the flu vaccination it is supposed to be written on the Resident's immunization form or MAR. When asked if she could find documentation regarding Resident #9's flu vaccination in his clinical record, she stated, "No." She also stated that she could not find nursing notes addressing the flu vaccine. LPN #1 presented an immunization log that she uses for tracking vaccinations. Resident #9 was documented as receiving the flu vaccine on 11/11/15. When asked if the log was part of the resident's clinical record she stated, "This log is for my own personal use." LPN #1 stated that the flu vaccination should have been documented in Resident #9's clinical record. On 4/20/16 at 6:04 p.m., administration was made aware of the above findings. No further information was presented prior to exit. Potter-Perry contains a quotation on page 477 regarding documentation as follows: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to clients. Effective	F 514		

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documentation ensures continuity of care, saves time, and minimizes the risks of errors (Yocum 2002)". Potter and Perry (2005) also includes the following information: "As members of the health care team nurses need to communicate information about clients accurately and in a timely, effective manner."

*Neurosyphilis- is a bacterial infection of the brain or spinal cord. It usually occurs in people who have had untreated syphilis for many years. This information was obtained from https://www.nlm.nih.gov/medlineplus/ency/article/000703.htm.

3. The facility staff failed to document in the clinical record that Resident #25 was transferred to the hospital.

Resident #25 was admitted to the facility on 2/19/16 with diagnoses that included but were not limited to: fracture of the humerus, urinary tract infection, gangrene of the left great toe, diabetes, high blood pressure, morbid obesity, depression, below the knee amputation, peripheral vascular disease.

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 3/4/16, coded the resident as scoring a seven on the BIMS (brief interview for mental status) indicating that she was severely impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance to being dependent upon one or more staff members for all of her activities of daily living. In Section M - Skin Conditions, the resident was coded as

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having a surgical wound.

The list of discharges for the past three months was requested upon entrance. Resident #25's name was listed with a discharge date of 3/23/16. It was documented that the resident was transferred to the hospital.

Review of the clinical record did not reveal a note documenting where or when the resident left the facility. The last documented nurse's note was dated, 3/23/16 at 10:49 a.m. There was nothing after that note.

Review of the physician orders did not reveal any documentation for a transfer to the hospital.

At the end of the day meeting on 4/20/16 at 6:18 p.m. it was requested for the facility to provide any documentation regarding the resident's transfer to the hospital.

On 4/21/16 at 10:55 a.m. an interview was conducted with RN (registered nurse), the unit manager, #4. When asked where the documentation was located, RN #4 stated, "She went out to the doctor's for an appointment and was sent directly to the hospital by the surgeon for wound debridement. When I went into the computer to write a note, the resident had already been discharged out of the system." When asked what happens when you can't document a nurse's note or anything in the chart related to that resident, RN #4 stated, "We revert to paper." When asked if she wrote a nurse's note, RN #4 stated, "I wrote a telephone order that she went to the hospital." Again, RN #4 was asked if she wrote a nurse's note on paper, RN #4 stated, "I don't know if the nurse caring for her wrote a

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note, I did not." When asked if there should be a nurse's note for a resident sent to the hospital, RN #4 stated, "I think so." RN #4 was for the telephone order she wrote. RN #4 presented a telephone order dated, 3/23/16 at 4:50 p.m. that documented, "Guest D/C'd (discharged) to hospital from MD (physician) office." When asked why this note was not in the clinical record, RN #4 stated, "I've had it sitting on my desk." When asked if this should have been in the clinical record as the resident was discharged on 3/23/16, RN #4 did not respond.

Documentation of the 24 hour report was presented on 4/21/16 at 11:15 a.m. from ASM (administrative staff member) #3, the regional QA (quality assurance) Manager. The 24 hour report documented, "ABT (antibiotics)/wound/URI (upper respiratory infection), MD appt (appointment) today at 9:40 a.m. Pick up at 9:00 a.m." The second entry documented, "ABT/Wound/URI out to MD appt - admitted to hospital."
When asked if there should be a nurse's note that the resident went out to a doctor's appointment and was directly admitted to the hospital, ASM #3 stated, "I would have written one." When asked if the 24 hour report sheets were part of the clinical record, ASM #3 stated, "No."

The administrator was made aware of the above concern on 4/21/16 at 12:15 p.m.