STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495114	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF ARLINGTON, LLC	1785 SOUTH HAYES STREET ARLINGTON, VA 22202

(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 08/02/16 through 08/04/16. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints were investigated during the survey. The census in this 240 certified bed facility was 145 at the time of the survey. The survey sample consisted of 23 current Resident reviews (Residents # 1 through 21 and # 26 through 27) and 4 closed record reviews (Residents # 22 through 25).	F 000	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225	**F-Tag 225** **Criterion #1 – Correction** Facility completed initial investigation, reinvestigated the incident for Resident #21 and submitted final FRI. **Criterion #2 – Other Potential** Incident reports for the past 30 days will be reviewed to ensure that all allegations of abuse have been reported and investigated. Identified variances will be investigated and reported per guidelines. A Resident Council meeting will be held to remind residents of their right to report all allegations of abuse; if any new allegations are identified during this meeting, they will be reported and investigated.	

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

Administrator 08/22/16

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F 225	Continued From page 1 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, facility staff failed to investigate and report an allegation of abuse for one of 27 residents in the survey sample, Resident #21. Facility staff failed to investigate and report an allegation of abuse to the State Agency involving Resident #21 and an employee that occurred in March 2016. Findings included: Resident #21 was admitted to the facility on 05/14/2015 with diagnoses including, but not limited to: Bipolar Disorder, Chronic Kidney Disease, Hypothyroidism, Hypotension (low Blood pressure) and Urinary Retention. The most recent MDS (minimum data set) was	F 225	**Criterion #3 – System Change** Staff from all departments will receive ongoing education on identifying and reporting abuse New staff will receive education on identifying and reporting abuse during orientation Facility leadership staff has received education from a long-term care consultant on completing comprehensive investigations for allegations of abuse. Resident Council meeting will be held and resident's reminded of their right to report all allegations of abuse.	

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F 225	Continued From page 2	F 225		

an annual assessment with an ARD (assessment reference date) of 05/19/2016. Resident #21 was assessed as cognitively intact with a total cognitive score of 14 out of 15.

Resident #21's EMR (electronic medical record) was reviewed on 08/03/2016 at 4:10 p.m. and again on 08/04/2016 at 8:00 a.m. Under the "Progress Notes" an "Incident Note" dated 3/31/2016 at 17:20 (5:20 p.m.) read, "At start of shift,resident [sic] stated that she placed a call to Asst. [assistant] Administrator to report assigned aide [Name], that on Thursday 3/24/16, while giving her shower,CNA [sic] [certified nursing assistant] [Name] did touch her inappropriately around her private area." This note was signed by the LPN (licensed practical nurse).

An "Incident Note" dated 4/1/2016 at 14:53 (2:43 p.m.) read, "This writer and Social Worker met with resident who had an alleged abuse complain. [sic] Resident stated, [Name] was patting me on my butt saying you have a nice butt and I told her that I am not gay and she got fired yesterday. Resident told us that the incident happened last week Thursday 03/24/2016 at 8pm in the shower room when she was being assisted with her scheduled shower..." This note was signed by the Unit Manager.

A "Social Services Note" dated 4/1/2016 at 16:22 (4:22 p.m.) read, "Writer, [Name], unit manager, and [Name] from nursing, interviewed resident about incident with an aide reported by her on 3/31/16 (See incident note dated 3/31/16.) [sic] Resident stated that the incident occurred a week ago on Thursday, and just reported it to staff that the aide [Name] was giving her a shower and patted her backside, stating 'Nice butt, Nice butt.'

Criterion #4 – Monitoring
A tracking system will be maintained by the SW department to ensure that all reported allegations are submitted timely and comprehensively investigated. The SW department will trend the report for types of allegations, needed education or changes in facility practice monthly and report of their analysis will be provided to the QA Committee for additional oversight and recommendation.

Criterion #5 – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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Referring to the aide, resident stated several times during the interview, 'She got fired.' Resident stated that she doesn't want that aide anymore and only wanted to go to the third floor..." This note was signed by Social Services.

A "Social Services Note" dated 4/1/2016 at 16:23 (4:23 p.m.) read, "Writer met with resident to discuss further the allegation about her aide...Writer asked resident why she waited a week to report the incident and she stated, 'It was the Percocet and I was confused. I don't know what Thursday it happened.' Unit manager informed." Note signed by Social Services.

A "Communication with Family/NOK/POA" dated 4/1/2016 at 17:28 (5:28 p.m.) read, "Call placed to residents son, R.P. [responsible party] stated " I received a call from my mom she said that someone touch her peri area during shower, [sic] I explain to her that some one has to clean and touch that area during shower to keep you clean, she said ok" [sic] she called me again yesterday, said I don't want to take shower..." [sic]

On 08/04/2016 at approximately 9:00 a.m. this surveyor asked the DON (director of nursing) for any information or investigation regarding the above alleged abuse. The DON stated, "I will get it for you."

At approximately 10:30 a.m. LNHA Consultant (licensed nursing home administrator), identified as Admin. (administration) #4 came to the conference room and stated, "I know this was not reported. I can only find what you have seen in the progress notes. We can't find any investigation." At 10:55 a.m., Admin. #4 brought this surveyor a copy of "Quality Improvement

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F 225	Continued From page 4	F 225		

Committee Minutes" dated "April 2016." Included in the minutes was the following, "...[Room number] - On 3/31/16-Resident reported that aide touched her inappropriately and made suggestive comments 'nice butt, nice butt,' when giving res [resident] a shower. Action: Interview with aide, aide suspended, physical exam of resident, interviews of resident by nursing and SW [social work], Reported to the State..." [sic] Admin. #4 explained these minutes were "Social Work Log of Incidents. There was no report in the FRI (facility reported incident) folder. I have them diligently looking for something. The Social Worker who looked at this is no longer here. They are calling her to see if she remembers anything." Pertaining to the CNA mentioned in the allegation Admin. #4 stated, "She does still work here. Was hired 5/1/15."

At approximately 11:05 a.m. the Assistant Administrator identified as Admin. #2 was interviewed regarding the Incident Note from 3/31/16 at 5:20 p.m. Admin. #2 stated, "I have never spoken with this resident regarding anything about abuse or any other incident. Today is the first I have heard of it."

Resident #21 was interviewed at approximately 11:15 a.m. Resident #21 stated, "It was [Name]. She was patting me on the butt saying nice butt, nice butt. I reported it to [Name] [Assistant Administrator]. She isn't allowed to give me showers anymore. She is on the other side. [Resident was referring to the other hallway on her unit]. She didn't say butt. She said nice ass. I told her to back off I'm not gay. She laughed at me, but didn't touch me anymore. She isn't allowed to give me showers anymore. She works on the other hall. I see her, but she doesn't

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F 225	Continued From page 5	F 225		

bother me. I'm okay with her up here as long as she doesn't mess with me. After the incident it was over and done. I do not feel anxious or threatened."

The Unit Manger, identified as LPN #8 was interviewed at approximately 11:25 a.m. LPN #8 stated, "I do remember an incident. There was an incident report done. Let me look at the chart and get my ducks in a row. Is that okay? There is a [Name], several really. [Name] is a very common name, like Joe Smith. There are a couple on this floor."

At approximately 11:35 a.m. two Social Workers, LPN #8 and the Administrator entered the conference room. The Social Worker identified as Other #3 stated, "We looked at the schedule and the accused person was not working on the 24th or the 25th. Her time card does not have any punches for those days either." When asked if any other CNA's or employees were interviewed regarding the alleged incident he stated, "No." When asked if the accused CNA was suspended pending investigation of the allegation Other #3 stated, "I don't know you would have to ask scheduling that."

The Administrator was interviewed and asked if he knew about the incident and if anyone was suspended pending the investigation. The Administrator stated, "I knew nothing about this until today. I didn't suspend anyone. The DON would have done that." When asked if he expected to be informed of any allegations of abuse and investigations the Administrator stated, "Yes." The Administrator stated, "If she was suspended there should be documentation in her employee file."

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The DON was interviewed at 11:55 a.m. The DON stated, "No, I did not suspend her. I did not know anything about it until today."

At 12:15 p.m. QA (quality assurance) meeting minutes for April and May 2016 were reviewed by the survey team. Allegations of abuse were not discussed in the QA meeting conducted either month.

At 12:25 p.m., Other #3 was interviewed regarding the QA Committee Minutes for April 2016. Other #3 stated, "Social Workers meet and discuss concerns or grievances from the month. We type up those concerns and email to the QA nurse to bring up in the QA meeting the next month. I don't know if those particular minutes were emailed or not. That QA nurse is no longer here. I do attend QA meetings, but don't recall if this was brought up or not."

At 12:30 p.m. Other #6 (former scheduler, now working in medical records) was interviewed regarding the schedule dated 3/13/2016 through 4/9/2016. Other #6 stated, "She [accused CNA] is off every Friday. CNA's work every other weekend. This was her weekend off. [Referring to 4/1/2016 through 4/3/2016]. She was full-time during this time. She went part-time about a month and a half ago." At approximately 12:40 p.m. Other #6 re-entered the conference room and stated, "During this time there was an incident and she may have been taken off the schedule. My supervisor told me to take her off. I don't know who told her."

At 12:45 p.m. this surveyor attempted to call the accused CNA and was connected to her

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voicemail. No message was left.

This CNA's Employee Record was reviewed by the survey team. No disciplinary actions were included in the record. Per the Administrator any disciplinary actions taken should be in the employee file.

No further information was received by the survey team prior to the exit conference on 08/04/2016.

F 226 483.13(c) DEVELOP/IMPLMENT F 226
SS=D ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, facility staff failed to implement their policy for abuse investigation and reporting for one of 27 residents in the survey sample, Resident #21.

Facility staff failed to investigate and report an allegation of abuse to the State Agency involving Resident #21 and an employee that occurred in March 2016.

Findings included:

Resident #21 was admitted to the facility on 05/14/2015 with diagnoses including, but not limited to: Bipolar Disorder, Chronic Kidney

F-Tag 226

Criterion #1 – Correction
Facility completed initial investigation, reinvestigated the incident for Resident #21 and submitted final FRI.

Criterion #2 – Other Potential
Incident reports for the past 30 days will be reviewed to ensure that all allegations of abuse have been reported and investigated. Identified variances will be investigated and reported per guidelines.

A Resident Council meeting will be held to remind residents of their right to report all allegations of abuse; if any new allegations are identified during this meeting, they will be reported and investigated.

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F 226	Continued From page 8	F 226	**Criterion #3 – System Change** Staff from all departments will receive ongoing education on identifying and reporting abuse New staff will receive education on identifying and reporting abuse during orientation Facility leadership staff has received education from a long-term care consultant on completing comprehensive investigations for allegations of abuse. Resident Council meeting will be held and resident's reminded of their right to report all allegations of abuse.	

Disease, Hypothyroidism, Hypotension (low Blood pressure) and Urinary Retention.

The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 05/19/2016. Resident #21 was assessed as cognitively intact with a total cognitive score of 14 out of 15.

Resident #21's EMR (electronic medical record) was reviewed on 08/03/2016 at 4:10 p.m. and again on 08/04/2016 at 8:00 a.m. Under the "Progress Notes" an "Incident Note" dated 3/31/2016 at 17:20 (5:20 p.m.) read, "At start of shift,resident [sic] stated that she placed a call to Asst. [assistant] Administrator to report assigned aide [Name], that on Thursday 3/24/16, while giving her shower,CNA [sic] [certified nursing assistant] [Name] did touch her inappropriately around her private area." This note was signed by the LPN (licensed practical nurse).

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A "Social Services Note" dated 4/1/2016 at 16:22 (4:22 p.m.) read, "Writer, [Name], unit manager, and [Name] from nursing, interviewed resident about incident with an aide reported by her on 3/31/16 (See incident note dated 3/31/16.) [sic]

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Resident stated that the incident occurred a week ago on Thursday, and just reported it to staff that the aide [Name] was giving her a shower and patted her backside, stating 'Nice butt, Nice butt.' Referring to the aide, resident stated several times during the interview, 'She got fired.' Resident stated that she doesn't want that aide anymore and only wanted to go to the third floor..." This note was signed by Social Services

A "Social Services Note" dated 4/1/2016 at 16:23 (4:23 p.m.) read, "Writer met with resident to discuss further the allegation about her aide...Writer asked resident why she waited a week to report the incident and she stated, 'It was the Percocet and I was confused. I don't know what Thursday it happened.' Unit manager informed." Note signed by Social Services.

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On 08/04/2016 at approximately 9:00 a.m. this surveyor asked the DON (director of nursing) for any information or investigation regarding the above alleged abuse. The DON stated, "I will get it for you."

At approximately 10:30 a.m. LNHA Consultant (licensed nursing home administrator), identified as Admin. (administration) #4 came to the conference room and stated, "I know this was not

Criterion #4 – Monitoring
A tracking system will be maintained by the SW department to ensure that all reported allegations are submitted timely and comprehensively investigated. The SW department will trend the report for types of allegations, needed education or changes in facility practice monthly and report of their analysis will be provided to the QA Committee for additional oversight and recommendation.

Criterion #5 – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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reported. I can only find what you have seen in the progress notes. We can't find any investigation." At 10:55 a.m., Admin. #4 brought this surveyor a copy of "Quality Improvement Committee Minutes" dated "April 2016." Included in the minutes was the following, "...[Room number] - On 3/31/16-Resident reported that aide touched her inappropriately and made suggestive comments 'nice butt, nice butt,' when giving res [resident] a shower. Action: Interview with aide, aide suspended, physical exam of resident, interviews of resident by nursing and SW [social work], Reported to the State..." [sic] Admin. #4 explained these minutes were "Social Work Log of Incidents. There was no report in the FRI (facility reported incident) folder. I have them diligently looking for something. The Social Worker who looked at this is no longer here. They are calling her to see if she remembers anything." Pertaining to the CNA mentioned in the allegation Admin. #4 stated, "She does still work here. Was hired 5/1/15."

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Resident #21 was interviewed at approximately 11:15 a.m. Resident #21 stated, "It was [Name]. She was patting me on the butt saying nice butt, nice butt. I reported it to [Name] [Assistant Administrator]. She isn't allowed to give me showers anymore. She is on the other side. [Resident was referring to the other hallway on her unit]. She didn't say butt. She said nice ass.

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I told her to back off I'm not gay. She laughed at me, but didn't touch me anymore. She isn't allowed to give me showers anymore. She works on the other hall. I see her, but she doesn't bother me. I'm okay with her up here as long as she doesn't mess with me. After the incident it was over and done. I do not feel anxious or threatened."

The Unit Manger, identified as LPN #8 was interviewed at approximately 11:25 a.m. LPN #8 stated, "I do remember an incident. There was an incident report done. Let me look at the chart and get my ducks in a row. Is that okay? There is a [Name], several really. [Name] is a very common name, like Joe Smith. There are a couple on this floor."

At approximately 11:35 a.m. two Social Workers, LPN #8 and the Administrator entered the conference room. The Social Worker identified as Other #3 stated, "We looked at the schedule and the accused person was not working on the 24th or the 25th. Her time card does not have any punches for those days either." When asked if any other CNA's or employees were interviewed regarding the alleged incident he stated, "No." When asked if the accused CNA was suspended pending investigation of the allegation Other #3 stated, "I don't know you would have to ask scheduling that."

The Administrator was interviewed and asked if he knew about the incident and if anyone was suspended pending the investigation. The Administrator stated, "I knew nothing about this until today. I didn't suspend anyone. The DON would have done that." When asked if he expected to be informed of any allegations of

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abuse and investigations the Administrator stated, "Yes." The Administrator stated, "If she was suspended there should be documentation in her employee file."

The DON was interviewed at 11:55 a.m. The DON stated, "No, I did not suspend her. I did not know anything about it until today."

At 12:15 p.m. QA (quality assurance) meeting minutes for April and May 2016 were reviewed by the survey team. Allegations of abuse were not discussed in the QA meeting conducted either month.

At 12:25 p.m., Other #3 was interviewed regarding the QA Committee Minutes for April 2016. Other #3 stated, "Social Workers meet and discuss concerns or grievances from the month. We type up those concerns and email to the QA nurse to bring up in the QA meeting the next month. I don't know if those particular minutes were emailed or not. That QA nurse is no longer here. I do attend QA meetings, but don't recall if this was brought up or not."

At 12:30 p.m. Other #6 (former scheduler, now working in medical records) was interviewed regarding the schedule dated 3/13/2016 through 4/9/2016. Other #6 stated, "She [accused CNA] is off every Friday. CNA's work every other weekend. This was her weekend off. [Referring to 4/1/2016 through 4/3/2016]. She was full-time during this time. She went part-time about a month and a half ago." At approximately 12:40 p.m. Other #6 reentered the conference room and stated, "During this time there was an incident and she may have been taken off the schedule. My supervisor told me to take her off.

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I don't know who told her."

At 12:45 p.m. this surveyor attempted to call the accused CNA and was connected to her voicemail. No message was left.

This CNA's Employee Record was reviewed by the survey team. No disciplinary actions were included in the record. Per the Administrator any disciplinary actions taken should be in the employee file.

The facility "Abuse Policy" with "Original Date: 4/30/2016" stated, "Purpose: The facility is committed to maintaining a safe and abuse-free environment for all residents and committed to conducting a comprehensive investigation of allegations of activities or situations that may constitute abuse...Outside entities, including regulatory agencies...will be notified and involved as appropriate to the situation...General Information [including definitions]: Types of Abuse...Sexual Abuse: unwanted sexual activity *Touching, feeling, making fun of,etc.. Specific Procedures/Requirements: ...IV. Identification...C. Staff are to immediately report allegations and/or observations of abuse to their immediate supervisor, manager on duty or director of nursing. Reports of allegations and/or observations of abuse will be made to the administrator...V. Investigation: A. Designated staff will immediately review and investigate all incident reports. B. The Quality Assurance Department will conduct analysis for trends and patterns related to allegations, injuries, incidents and/or unusual occurrences, reportable incidents, etc. C. The facility will investigate and report incidents or occurrences in accordance with federal and state regulations and guidelines. D.

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Outside investigative bodies, such as the local police will be contacted as directed by the administrator and in accordance with state and local law. VI. Protection: ...D. When specific staff is identified as being allegedly involved in the abuse allegation, the staff may be re-assigned or suspended during the investigation...VII. Reporting/Response: A. Report all alleged violations and all substantiated incidents to the State Agency...and take all necessary corrective actions depending on the results of the investigation..."

No further information was received by the survey team prior to the exit conference on 08/04/2016.

F 226

F 241 SS=D 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on resident interview and staff interview the facility staff failed to promote the dignity and respect for two of 27 residents in the survey sample: Resident # 18 and # 26. A staff person identified as the unit manager on the 4th floor was entering resident rooms without knocking, waiting for permission to enter, and touching residents without verbal consent to do so.

Findings include:

On 8/4/16 at 8:00 a.m. Resident # 26 was

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Criterion #1 – Correction
The identified staff member apologized to Resident #26 and the apology was accepted.

Resident #18 received an apology and was offered an explanation as to why it was unsafe to maintain a knife in his room. A back scratcher was provided for him to use.

The observed staff person has received one-on-one education on identifying self, seeking permission to enter resident rooms and obtaining consent prior to touching residents.

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overheard at the 2nd floor nursing station telling the unit secretary "And then he kept pushing on me, and pushing on me, he did not say what he wanted, just kept pushing on me..... this is America, I have rights, this isn't right! You cannot do that! Then he said 'Oh, no, it's not him, it's the roommate'." The unit secretary was heard to say "I'm calling up there right now and will get him to come down and apologize to you." The unit secretary was asked who "he" was, and she stated "[Name of staff member] was down here checking residents for hipsters (a device worn to help prevent injury from a fall)." The staff member was identified as licensed practical nurse (LPN) # 8, and was the unit manager from the 4th floor.

At 8:15 a.m., this surveyor, accompanied by another surveyor, went to Resident # 26's room. After knocking and given permission to enter, Resident # 26 was asked what had happened earlier. Resident # 26 stated "I was laying in bed, still asleep, and the nurse came in and just started rolling me over and pushing on me around my pocket area on my pants; did not say a word, just rolled me around and pushing on me. I felt violated, my rights were violated. This is America, and I have rights. Someone is not supposed to just walk in your room and start touching you! I don't like it; I don't want it done again. He [the nurse] was looking to see if I had on hipsters.....I don't." The resident's roommate confirmed that LPN # 8 had entered the room without knocking, and while LPN # 8 did not touch him, he confirmed the incident as Resident # 26 described it.

On 8/4/16 at 8:30 a.m. LPN # 8 was interviewed by this surveyor with another surveyor present.

Criterion #2 – Other Potential
All other residents may have potentially been impacted. In-service completed for staff from all department on importance of identifying self and knocking before entering resident rooms

Criterion #3 – System Change
In-service completed for staff from all department on importance of identifying self and knocking before entering resident rooms.

New hires will be educated on dignity and customer service during orientation.

Criterion #4 – Monitoring
Department Managers and/or designee will make frequent rounds to observe staff interaction with residents for dignity; observational data for 5 staff people per shift per unit will be done weekly x 6 weeks and then every other week x 2 months. Staff will be re-educated if variances are identified. Findings from the weekly observations will be given to Social Work for analysis of trends/patterns and any needed follow up with residents. A summary of the weekly observations will be provided to the QA Committee for additional oversight and recommendation.

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LPN # 8 was asked about the incident. LPN # 8 stated "I did tell him I needed to check him; he opened his eyes and said 'ummm'.....I took that as a yes. Maybe he didn't hear me; I talk fast." The surveyor then stated that since the resident was cognitive, and could answer yes or no, that an "ummmm" would indicate confusion, not consent. LPN # 8 agreed. LPN # 8 also stated he was on his way to talk with Resident # 26. This surveyor, LPN # 8, the ADON (assistant director of nursing), and another surveyor then proceeded to the resident's room. The surveyor knocked on the door, and the resident gave consent for us to enter. As LPN # 8 approached the resident, he became visibly agitated, and stated "That's him." LPN # 8 told Resident # 26 "I'm sorry you did not understand or hear me when I was checking you this morning." The resident, who still appeared agitated, stated to this surveyor "Look at this. I know what my rights are." The resident took out his wallet and handed this surveyor an identification card from when he worked for the Department of Defense. He looked at LPN # 8 and stated "OK, I forgive you, but don't ever do that again. I have rights, you violated my rights. Don't ever do that again. This is America."

On 8/4/16 at 9:45 a.m. during a resident interview with Resident # 18, he was asked if staff treated him with dignity and respect. Resident # 18 stated "Well, not all of them. A couple of weeks ago I had switched my dialysis days. [Name of LPN # 8] came walking in my room, didn't knock [because he thought I was at dialysis] and I was sitting behind my curtain. LPN # 8 came around the curtain and when he saw me there, he was startled...didn't expect it, and he had nothing to say, just looked at me. I asked him if he needed

Criterion #5 – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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something, and he saw a steak knife on my table that I had been using as a back scratcher. I had it for over 2 years. LPN # 8 picked it up and said "You can't have this." He had never said a word about it before that. Then he just left the room. After he left, my roommate told me LPN # 8 came in my room a lot when I was in dialysis..... I told the assistant administrator about it, and he's backed off some. I think they must have said something to him. Other than that I have no complaints."

On 8/4/16 beginning at 2:30 p.m. during an afternoon meeting, the DON (director of nursing), ADON, and the administrator were informed of the above findings. The administrator stated "We will look into that."

No further information was provided prior to the exit conference.

F 241

F 278 SS=D 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who

F 278

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Criterion #1 – Correction
Resident #13's MDS was modified on 08/15/16, has been submitted and accepted.

Criterion #2 – Other Potential
A 100% audit of all MDS of current residents with pressure ulcers will be completed for potential miscoding of Section M – pressure ulcers. Modifications to assessments will be made as needed and per guidance in the RAI manual.

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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 and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) for one of 27 residents, Resident #13.

Resident #13's MDS did not indicate a pressure ulcer.

Findings include:

Resident #13 was admitted to the facility on 4/15/13 with a readmission on 7/3/16 with diagnoses including but not limited to pressure ulcer.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/8/16. Resident #13 was assessed as being severely cognitively impaired.

Resident #13's electronic record was reviewed on 8/2/16 and evidenced, via MDS, section "M" with an ARD of 5/30/16 (annual) and 7/8/16 (quarterly)

Criterion #3 – System Change
MDS coordinators have completed a review of the RAI manual section "M" for coding accuracy.

Criterion #4 – Monitoring
A weekly audit of 2 assessments [of residents with pressure ulcers] per week x 6 weeks will be conducted to ensure accurate coding of section "M" (the two MDS coordinators will review each other's section "M") and this audit will be overseen by the DON/ADON or designee for trending. Variances will be investigated and corrections made as appropriate. An analysis of the weekly audits will be given to the QA Committee.

Criterion #5 – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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that Resident #13 did not have any pressure ulcers, wounds or healing pressure ulcers.

Further review of Resident #13's clinical record documented (via wound clinic) that Resident #13 was going to the wound clinic beginning 4/28/16 through 5/26/16 weekly due to a "...unstageable (due to necrosis) of the left buttock of at least 1 days duration."

According to the wound clinic documentation dated 5/26/16, Resident #13's wound had changed, "presents with a stage 3 pressure wound of the left buttock of at least 26 days duration."

On 8/2/16 at 10:50 a.m. with the permission of Resident #13, Resident #13's buttocks was observed and found to be healed of any open or scabbed wounds.

On 8/2/16 at 2:15 p.m., the MDS coordinator (identified as license practical nurse, LPN #6) was interviewed. LPN #6 verbalized that she was assigned to do Resident #13's MDS assessment. This surveyor provided LPN #6 with the above information. LPN #6 verbalized that the wound should have been captured on both MDS's, verbalizing that it was missed.

On 8/2/16 at 4:10 p.m. the above finding was brought to the attention of the director of nursing (DON) and administrator during an end of day meeting.

No further information was presented prior to exit conference on 8/4/16.

The Long-Term Care Facility Resident

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F 278	Continued From page 20 Assessment Instrument User's Manual on page M-5 states concerning coding of pressure ulcers, "Code based on the presence of any pressure ulcer (regardless of stage) in the past 7 days ..Code 1, yes: if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to Current Number of Unhealed Pressure Ulcers at Each Stage item (M0300)." (1) (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.13, Centers for Medicare & Medicaid Services, October 2015.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	**F-Tag 279** **Criterion #1 – Correction** Resident #13's psychoactive care plan initiated and individualized on 8/15/16. **Criterion #2 – Other Potential** A 100% audit of all care plans of current residents on psychoactive medications will be reviewed and revised as necessary to address use of the psychoactive medications. **Criterion #3 – System Change** The interdisciplinary team will be re-educated on the importance of comprehensive care plan and reminded to include use of psychoactive medications on the care plan as appropriate.	

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This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of 27 residents, Resident #13.

Resident #13 did not have a comprehensive care plan to include psychoactive medications.

Findings include:

Resident #13 was admitted to the facility on 4/15/13 with a readmission on 7/3/16 with diagnoses including but not limited to depression.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/8/16. Resident #13 was assessed as being severely cognitively impaired.

Resident #13's electronic record was reviewed on 8/2/16 and evidenced, via MDS, section "V" that Resident #13 had triggered for a care plan for psychoactive medications, due to antidepressant medications secondary to a diagnoses of depression.

Further review of Resident #13's clinical record did not evidence that a care plan had been developed for psychoactive medications.

On 8/2/16 at 2:40 p.m. an interview with the unit manager took place (where Resident #13 resides) identified as license practical nurse (LPN #8). LPN #8 was asked about the missing care plan. LPN #8 reviewed the information provided

Criterion #4 – Monitoring
A weekly audit of 6 care plans of residents on psychoactive medications will be done x 6 weeks and then twice a month x 2 months by the MDS coordinator and/or designee to ensure that the plan addresses use of the psychoactive medication; findings will be reported to the DON/ADON for trends/patterns. An analysis of the weekly audits will be given to the QA Committee for additional oversight and recommendation.

Criterion #5 – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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and reviewed Resident #13's care plan. LPN #8 verbalized that he was not sure why the care plan was not done, but would look into the concern.

On 8/2/16 at 4:10 p.m. the above finding was brought to the attention of the director of nursing (DON) and administrator during an end of day meeting. The DON verbalized the concern would be looked into.

On 8/3/16 at 7:30 a.m. the survey team entered the facility and found information in the conference room that was asked for by the team the previous day. Information was not provided for the above finding. At this time, this surveyor again asked the DON for information concerning Resident #13's care plan. The DON verbalized that she had not found any information as to why the care plan was not done.

No further information was presented prior to exit conference on 8/4/16.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
SS=D

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,

F 279

F 280

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Criterion #1 – Correction
Resident #10's care plan personalized on 8/15/16 to address pressure ulcer, including treatment.

Criterion #2 – Other Potential
A 100% audit of care plans of current residents with pressure ulcers will be reviewed and plans revised as appropriate address pressure ulcers.

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and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to review and revise the CCP (comprehensive care plan) for one of 27 residents in the survey sample, Resident # 10.

Facility staff failed to review and revise a CCP (comprehensive care plan) for Resident #10 regarding pressure wounds and treatment.

Findings include:

Resident #10 was admitted to the facility on 03/25/2016 and readmitted on 06/10/2016 with diagnoses including, but not limited to: Altered Mental Status, End Stage Renal Disease, Colon Cancer, Hypertension (high blood pressure) and Pressure Wounds.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/08/2016. Resident #10 was assessed as severely impaired in his cognitive status with a total cognitive score of 05 (five) out of 15.

Resident #10's EMR (electronic medical record) was reviewed on 08/02/2016 at 9:40 a.m. During this review a "Wound Care Specialist Evaluation"

Criterion #3 – System Change
The interdisciplinary team will be re-educated by an independent long - term care consultant on the importance of revising the plan of care as the resident's condition changes and to reflect current treatment interventions.

Criterion #4 – Monitoring
A weekly audit of 6 care plans of residents with pressure ulcers will be done x 6 weeks and then twice a month x 2 months by the MDS coordinator and/or designee to ensure that the plan appropriately addresses pressure ulcer care; findings will be reported to the DON/ADON for trends/patterns. An analysis of the weekly audits will be given to the QA Committee for additional oversight and recommendation.

Criterion #5 – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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dated 7/14/2016 was located and contained the following: "Wound of the Right, Second Toe, Unstageable DTI [deep tissue injury] Sacrum and Stage 3 Pressure Wound of the Right Heel."

The CCP for Resident #10 included the following information regarding wounds: "Focus: The resident is at nutritional risk r/t [related to] prolonged illness and unhealed wounds...Goals: Wound will show improvement and no new skin breakdown as a result of malnutrition Interventions: Monitor wound healing progress...Focus: The resident actual skin alteration: Pressure ulcers Goal: This resident wound will show signs of healing and be free of complications by next review. Interventions: Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Encourage good nutrition and hydration in order to promote healthier skin. Keep fingernails short and trimmed. Keep skin clean and dry...Treatment as ordered weekly wound round."

The CCP does not identify wound sites or treatments. Also there is no mention of Resident #10 being followed by the wound care team and wound care doctor that visits the facility.

The DON (director of nursing) was interviewed regarding CCP's and updates to care plans on 08/03/2016. She stated, "MDS nurses and Unit Managers should update care plans with quarterly assessments and any other time there is a change in the resident's plan of care."

The Administrator was informed of the above information during a meeting with the survey team on 08/03/2016 at approximately 4:00 p.m. No further information was received by the survey

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team prior to the exit conference on 08/04/2016.

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

F 281

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

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to follow professional standards of nursing practice for one of 27 residents in the survey sample. Resident #2 was administered the blood pressure medication Metoprolol on 26 days in July 2016 without a prior assessment of blood pressure and heart rate.

The findings include:

Resident #2 was admitted to the facility on 7/9/11 with re-admission on 4/25/16. Diagnoses for Resident #2 included high blood pressure, coronary artery disease, diabetes, dementia and bipolar disorder. The minimum data set (MDS) dated 6/14/16 assessed Resident #2 with short and long-term memory problems and modified independent cognitive skills (difficulty with new situations only).

Resident #2's clinical record documented a physician's order dated 6/7/16 for the medication Metoprolol 75 mg (milligrams) to be administered each day for the treatment of high blood pressure. The order included instructions to hold the medication if the systolic blood pressure was less than or equal to 100 or if the resident's heart

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Criterion #1 – Correction
Resident #2 has not demonstrated any adverse outcome. The resident's electronic medical record has been modified to prompt documentation of blood pressure and heart rate. Nursing staff is being re-educated on the importance of obtaining and documenting blood pressure and heart rate prior to administration of medication as ordered by the physician.

Criterion #2 – Other Potential
A 100% audit will be done for current residents with orders to monitor blood pressure and heart rate prior to administration of an antihypertensive to ensure that the record prompts nursing staff to document the blood pressure and heart rate. Nursing staff will be re-educated on the importance of obtaining and documenting blood pressure and heart rate prior to administration of antihypertensive medication as ordered by the physician.

Nursing staff will be re-educated in entering orders into the electronic medical record to include physician orders for taking blood pressure and heart rate prior to administration of medications as ordered by the physician.

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F 281	Continued From page 26 rate was less than or equal to 60. Resident #2's medication administration record (MAR) for July 2016 documented 26 days the Metoprolol 75 mg was administered without a prior blood pressure or heart rate assessment to determine if the medication should have been held. The clinical record documented Metoprolol 75 mg was administered with no prior blood pressure or heart rate assessments on 7/1/16, 7/3/16 through 7/8/16, 7/10/16 through 7/14/16, 7/16/16 through 7/18/16, 7/20/16 through 7/29/16, and 7/31/16. The July 2016 MAR documented Metoprolol was administered each day at 9:00 a.m. Blood pressure and heart rate assessments were listed in the record on the following days but they were not done at the time the Metoprolol was administered. Blood pressures and heart rates were listed on 7/16/16 at 11:47 a.m., 7/17/16 at 1:53 p.m., 7/18/16 at 10:30 p.m., 7/20/16 at 10:28 p.m., 7/23/16 at 2:03 p.m., 7/24/16 at 7:32 p.m. and 7/25/16 at 3:40 p.m. On 8/2/16 at 2:20 p.m. the licensed practical nurse (LPN #4) administering medications to Resident #2 was interviewed about the physician ordered parameters for holding the Metoprolol. LPN #4 stated she checked the resident's blood pressure and heart rate each day to determine if she was to administer the Metoprolol. When asked where the blood pressure and heart rate assessments were listed, LPN #4 stated she recorded the information in her nursing notes. When asked about the Metoprolol she administered on 8/2/16 at 9:00 a.m., LPN #4 stated she had not written the resident's blood pressure and heart rate down yet. LPN #4 stated, "I will put it [blood pressure, heart rate] in my notes when I write them today." LPN #4 stated	F 281	**Criterion #3 – System Change** Nursing staff will be re-educated on the importance of obtaining and documenting blood pressure and heart rate prior to administration of antihypertensive medication as ordered by the physician Night supervisor to verify or monitor nurses completing 24hrs chart check daily Nursing staff will be re-educated in entering orders into the electronic medical record to include physician orders for taking blood pressure and heart rate prior to administration of medications as ordered by the physician. **Criterion #4 – Monitoring** Weekly x 6 and then every other week x 2 months, 5 new admissions/re-admissions orders will be validated for accurate entry into the resident's medical record; audits will be conducted by Unit Managers and/or designee and findings given to DON/ADON for tracking of patterns. Variances will be investigated and corrections made as appropriate. An analysis of the weekly audits will be provided to the QA Committee for additional oversight and recommendation.	

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she had not written the blood pressure and heart rate for 8/2/16 down anywhere but "just remembered" them and would record them at the end of her shift. When asked about the days in July 2016 when Metoprolol was administered without any prior blood pressure or heart rate, LPN #4 stated she did not work yesterday.

On 8/2/16 at 2:40 p.m. the unit manager (LPN #3) was interviewed about Resident #2's Metoprolol administered without prior blood pressure or heart rate assessments as ordered. LPN #2 stated the nurses only recorded the blood pressure and heart rates if they held the medication. LPN #2 stated there were spaces in their computer system to record blood pressure and heart rate measurements. LPN #3 was asked how she knew the nurses were following the hold parameters for the Metoprolol if blood pressures or heart rates were only recorded when the medication was held. LPN #3 had no response.

The clinical record including nursing notes documented no blood pressure or heart rate assessments other than those listed above. There were no notes that the Metoprolol was held on any days in July 2016.

On 8/3/16 at 2:50 p.m. the director of nursing (DON) was interviewed about Resident #2's Metoprolol administration without associated blood pressure and heart rate assessments. The DON stated blood pressure and heart rates were supposed to be checked at the time of the medication pass to determine in the medication was to be held or administered. The DON stated blood pressure and heart rate assessments were supposed to be recorded in the clinical record at the time they were taken. The DON stated their

Weekly x6 and then every other week x 2 months, 5 residents with orders to have blood pressure and heart rate taken prior to administration of medications, will have MARs [medication administration record] reviewed to ensure parameters are being taken, documented and followed. Variances will be investigated, staff re-educated as needed. The Unit Manager and/or designee will complete the audits and forward to DON/ADON for analysis of trends/patterns. A summary report of the audits will be provided to QA Committee for additional oversight and recommendation.

Criterion #5 – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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computerized system provided entry spaces for blood pressures and heart rates.

On 8/4/16 at 7:45 a.m. the DON was interviewed about LPN #4 stating she assessed Resident #2's blood pressure and heart rate prior to giving the Metoprolol on 8/2/16 but was not going to record it until the end of the shift. The DON stated she had recognized late documentation as an issue with some of her nurses. The DON stated assessments were supposed to be documented at the time they were done.

No other information was presented regarding Resident #2's blood pressure and heart rate assessments associated with the administration of the daily Metoprolol.

The Drug Information Handbook for Nursing 13th edition on page 801 describes Metoprolol and a beta-blocker used for the treatment of high blood pressure, angina or myocardial infarction (heart attack). This reference includes low blood pressure and slow heart rate as adverse reactions associated with the medication. Page 803 of this reference includes under nursing actions/assessments for Metoprolol, "Monitor blood pressure and cardiac status..." Page 804 of this reference states, "Take pulse daily prior to medication and follow prescriber's instruction about holding medication." (1)

The Drug Information Handbook for Nursing 13th edition on pages 12 and 13 states concerning safe medication administration, "Assessment is the primary action in the nursing process and it is also a vital part of optimal drug therapy. Assessment activities must precede administering any medications...at all times, the

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nurse responsible for administering the medication or instructing the patient about administration is also responsible for monitoring effectiveness and adverse effects and communicating these details to the prescriber...Awareness of the need for monitoring, the rationale behind monitoring instructions, and the type of monitoring required is a nursing responsibility." (1)

The Lippincott Manual of Nursing Practice 10th edition on page 16 states concerning standards of nursing practice, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events." This reference on page 16 states concerning departures from the standards of nursing care, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered..." (2)

These findings were reviewed with the administrator and director of nursing on 8/2/16 at 4:00 p.m.

(1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.

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(2) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

F 309 SS=E 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review the facility staff failed to follow physician orders for three of 27 residents in the survey sample: Residents # 8, # 2 and # 4.

1. Resident # 8's blood pressure and pulse was not obtained prior to the administration of blood pressure medicine per the physician order.

2. Resident # 2's blood pressure and pulse was not obtained prior to the administration of blood pressure medicine per the physician order.

3. Resident #4 did not receive two physician ordered medications. Colace 100 mg (milligrams) was ordered to be given twice a day and Senna 8.6 mg was ordered to be given at bedtime on Monday, Wednesday, and Friday. Colace is a stool softener and Senna is a natural herbal laxative. The medications were ordered

F 309

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Criterion #1 – Correction

Resident #8 has not demonstrated any adverse outcome. The resident's electronic medical record has been modified to prompt documentation of blood pressure and heart rate. The physician has been notified of the blood pressures and heart rate that were not documented.

Resident #2 has not demonstrated any adverse outcome. The resident's electronic medical record has been modified to prompt documentation of blood pressure and heart rate. The physician has been notified of the blood pressures and heart rate that were not documented

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on 07/13/2016 by the physician but the orders were not implemented by the facility staff.

Findings include:

1. Resident # 8's blood pressure and pulse were not obtained prior to the administration of blood pressure medication as ordered by the physician.

Resident # 8 was initially admitted to the facility 5/23/15 with a readmission date of 10/16/15. Diagnoses for resident # 8 included, but were not limited to: high blood pressure, dementia without behaviors, and acute (abrupt decline in function) kidney failure.

The most recent MDS (minimum data set) was a quarterly review dated 7/8/16. Resident # 8 was coded as having short term and long term memory problems, and moderately impaired in daily decision making skills.

The medical record was reviewed 8/2/16 at 11:00 a.m. The current August 2016 POS (physician order summary) included an order carried forward from 1/2016 for "Metoprolol Tartrate [a medication to control high blood pressure] 50 mg [milligrams] 1 tablet orally [by mouth] two times a day for hypertension [high blood pressure]. Hold for systolic [top number] blood pressure less than 110 and heart rate less than 60."

The MAR (medication administration record) for June 2016, July 2016 and August 2016 was reviewed. There was no documentation of the resident's blood pressure or heart rate readings located on the MAR beside the area for documentation of the medication.

Nursing staff is being re-educated on the importance of obtaining and documenting blood pressure and heart rate prior to administration of medication as ordered by the physician. The physician has been notified of the blood pressures and heart rate that were not documented

Resident #4 has received bowel medication as ordered by the physician since 8/3/2016; the resident has not experienced any adverse effects. The physician was notified of the bowel medications that had not been documented as having been administered.

Criterion #2 – Other Potential
A 100% audit will be done for current residents with orders to monitor blood pressure and heart rate prior to administration of an antihypertensive to ensure that the record prompts nursing staff to document the blood pressure and heart rate. Nursing staff will be re-educated on the importance of obtaining and documenting blood pressure and heart rate prior to administration of antihypertensive medication as ordered by the physician.

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F 309	Continued From page 32 On 8/3/16 at 1:40 p.m. the ADON (assistant director of nursing) was asked where the documentation for the blood pressure (BP) and heart rate (HR) would be. The ADON stated "If it's not documented here [on the MAR] then we don't have it." During a meeting with facility staff 8/3/16 beginning at 2:30 p.m. the DON (director of nursing) was informed of the above findings. The DON was asked what the expectation for taking the blood pressure and heart rate. The DON stated "The expectation is the vitals [BP and HR] be done and documented prior to administering the medication." No further information was provided prior to the exit conference. 2. Facility staff failed to follow a physician's order regarding the administration of the medication Metoprolol for Resident #2. Nurses administered Metoprolol for 26 days in July 2016 without prior blood pressure or heart rate assessments needed to follow physician ordered parameters for holding the medication. Resident #2 was admitted to the facility on 7/9/11 with re-admission on 4/25/16. Diagnoses for Resident #2 included high blood pressure, coronary artery disease, diabetes, dementia and bipolar disorder. The minimum data set (MDS) dated 6/14/16 assessed Resident #2 with short and long-term memory problems and modified	F 309	A 100% chart review will be conducted for current residents to ensure that physician orders since 8/5/2016 have been entered into the medical record. CNA staff will be re-educated on accurate documentation of bowel movements. **Criterion #3 – System Change** Nursing staff will be re-educated on the importance of obtaining and documenting blood pressure and heart rate prior to administration of antihypertensive medication as ordered by the physician Nursing staff will be re-educated in entering orders into the electronic medical record to include physician orders for taking blood pressure and heart rate prior to administration of medications as ordered by the physician. Night supervisors will be re-educated in facility process to verify or monitor nurses completing 24hr. chart check daily to ensure that physician orders have been entered into the medical record	

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F 309	Continued From page 33 independent cognitive skills (difficulty with new situations only). Resident #2's clinical record documented a physician's order dated 6/7/16 for the medication Metoprolol 75 mg (milligrams) to be administered each day for the treatment of high blood pressure. The order included instructions to hold the medication if the systolic blood pressure was less than or equal to 100 or if the resident's heart rate was less than or equal to 60. Resident #2's medication administration record (MAR) for July 2016 documented 26 days the Metoprolol 75 mg was administered without a prior blood pressure or heart rate assessment to determine if the medication should have been held. The clinical record documented Metoprolol 75 mg was administered with no prior blood pressure or heart rate assessments on 7/1/16, 7/3/16 through 7/8/16, 7/10/16 through 7/14/16, 7/16/16 through 7/18/16, 7/20/16 through 7/29/16, and 7/31/16. The July 2016 MAR documented Metoprolol was administered each day at 9:00 a.m. Blood pressure and heart rate assessments were listed in the record on the following days but they were not done at the time the Metoprolol was administered. Blood pressures and heart rates were listed on 7/16/16 at 11:47 a.m., 7/17/16 at 1:53 p.m., 7/18/16 at 10:30 p.m., 7/20/16 at 10:28 p.m., 7/23/16 at 2:03 p.m., 7/24/16 at 7:32 p.m. and 7/25/16 at 3:40 p.m. On 8/2/16 at 2:20 p.m. the licensed practical nurse (LPN #4) administering medications to Resident #2 was interviewed about the physician ordered parameters for holding the Metoprolol. LPN #4 stated she checked the resident's blood pressure and heart rate each day to determine if	F 309	The facility has developed a bowel management policy and the Medical Director has approved it. Nursing staff will be educated on the policy. Resident's will have individualized bowel protocols as ordered by the physician and the physician will be notified when the resident does not have regular bowel movements or when the implemented protocols are not successful. CNA staff will be re-educated on accurate documentation of bowel movements. The EMR will post a flag on the dashboard alerting the clinical team when a resident has not had a bowl movement for three days. The Unit Managers and/or the nurses monitor the dashboard daily to address any flags regarding resident bowel movements. If an electronic flag is generated the facility bowel management policy will be followed	

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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 309	Continued From page 34	F 309	**Criterion #4 – Monitoring**	

she was to administer the Metoprolol. When asked where the blood pressure and heart rate assessments were listed, LPN #4 stated she recorded the information in her nursing notes. When asked about the Metoprolol she administered on 8/2/16 at 9:00 a.m., LPN #4 stated she had not written the resident's blood pressure and heart rate down yet. LPN #4 stated, "I will put it [blood pressure, heart rate] in my notes when I write them today." LPN #4 stated she had not written the blood pressure and heart rate for 8/2/16 down anywhere but "just remembered" them and would record them at the end of her shift. When asked about the days in July 2016 when Metoprolol was administered without any prior blood pressure or heart rate, LPN #4 stated she did not work yesterday.

On 8/2/16 at 2:40 p.m. the unit manager (LPN #3) was interviewed about Resident #2's Metoprolol administered without prior blood pressure or heart rate assessments as ordered. LPN #2 stated the nurses only recorded the blood pressure and heart rates if they held the medication. LPN #2 stated there were spaces in their computer system to record blood pressure and heart rate measurements. LPN #3 was asked how she knew the nurses were following the hold parameters for the Metoprolol if blood pressures or heart rates were only recorded when the medication was held. LPN #3 had no response.

The clinical record including nursing notes documented no blood pressure or heart rate assessments other than those listed above. There were no notes that the Metoprolol was held on any days in July 2016.

On 8/3/16 at 2:50 p.m. the director of nursing

Weekly x 6 and then every other week x 2 months, 5 new admissions/re-admissions orders will be validated for accurate entry into the resident's medical record; audits will be conducted by Unit Managers and/or designee and findings given to DON/ADON for tracking of patterns. Variances will be investigated and corrections made as appropriate. An analysis of the weekly audits will be provided to the QA Committee for additional oversight and recommendation.

Weekly x6 and then every other week x 2 months, 5 residents with orders to have blood pressure and heart rate taken prior to administration of medications, will have MARs [medication administration record] reviewed to ensure parameters are being taken, documented and followed. Variances will be investigated, staff re-educated as needed. The Unit Manager and/or designee will complete the audits and forward to DON/ADON for analysis of trends/patterns. A summary report of the audits will be provided to QA Committee for additional oversight and recommendation.

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(DON) was interviewed about Resident #2's Metoprolol administration without associated blood pressure and heart rate assessments. The DON stated blood pressure and heart rates were supposed to be checked at the time of the medication pass to determine in the medication was to be held or administered. The DON stated blood pressure and heart rate assessments were supposed to be recorded in the clinical record at the time they were taken. The DON stated their computerized system provided entry spaces for blood pressures and heart rates.

On 8/4/16 at 7:45 a.m. the DON was interviewed about LPN #4 stating she assessed Resident #2's blood pressure and heart rate prior to giving the Metoprolol on 8/2/16 but was not going to record it until the end of the shift. The DON stated she had recognized late documentation as an issue with some of her nurses. The DON stated assessments were supposed to be documented at the time they were done.

No other information was presented regarding Resident #2's blood pressure and heart rate assessments associated with the administration of the daily Metoprolol.

The Drug Information Handbook for Nursing 13th edition on page 801 describes Metoprolol and a beta-blocker used for the treatment of high blood pressure, angina or myocardial infarction (heart attack). This reference includes low blood pressure and slow heart rate as adverse reactions associated with the medication. Page 803 of this reference includes under nursing actions/assessments for Metoprolol, "Monitor blood pressure and cardiac status..." Page 804 of this reference states, "Take pulse daily prior to

Unit Managers and/or designee will review bowel movement records of 5 residents' weekly x 6 and then every other week x2 months to ensure that records are being completed and physician orders being carried out related to bowel management. Variances will be investigated, staff re-educated as needed, and resident care provided per physician orders. The weekly audits will be given to DON/ADON for analysis and trending of patterns. A summary report of the weekly audits will be given to the QA Committee for additional oversight and recommendation.

Criterion #5 – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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medication and follow prescriber's instruction about holding medication." (1)

These findings were reviewed with the administrator and director of nursing on 8/2/16 at 4:00 p.m.

(1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.

3. Resident #4 did not receive two physician ordered medications. Colace 100 mg (milligrams) was ordered to be given twice a day and Senna 8.6 mg was ordered to be given at bedtime on Monday, Wednesday, and Friday. Colace is a stool softener and Senna is a natural herbal laxative. The medications were ordered on 07/13/2016 by the physician but the orders were not implemented by the facility staff.

Findings were:

Resident #4 was admitted to the facility on 03/24/2015 with the following diagnoses, but not limited to: Unspecified mood disorder, hypertension (high blood pressure), depressive disorder, chronic ischemic heart disease (heart problems), history of falling and a traumatic brain injury.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/25/2016. Resident #4 was assessed as having difficulty with both long and

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short term memory, as well as being moderately impaired with daily decision making skills.

The paper/hard chart clinical record was reviewed on 08/02/2016. Observed in the front of the physician order section was an order handwritten by the physician on 07/13/2016. The order read: "Colace 100 mg PO [by mouth] BID [twice a day]. Senna 8.6 mg PO QHS [every bedtime] Monday, Wednesday, Friday. Hold for loose stools." The electronic medical record was also reviewed. The above order was not on the current POS (physician order sheet) located in the electronic record. The electronic MAR (medication administration) for July and August was reviewed. There were no entries for either of the medications on the MAR.

The medication nurse, LPN (licensed practical nurse) #7 was interviewed on 08/02/2016 at approximately 3:15 p.m. regarding the medications, Colace and Senna. She reviewed the electronic physician orders and the electronic MAR. She also reviewed the handwritten order in the clinical record. She also had the unit manager, LPN #3 do the same. LPN #3 stated, "I don't see it on there." She was asked who's responsibility it was to take orders off of the clinical record. She stated, "The night nurse audits the orders."

The bowel records were reviewed. There were three questions listed on the bowel record. Question #1 was "Bowel Continence" Choices were "Continent, incontinent, No Bowel Movement, Continence not Rated due to ostomy, resident not available, resident refused, and not applicable" Question #2 was "Size of BM (bowel movement)". Choices were: "Small, medium,

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large, resident not available, resident refused, and not applicable." Question #3 was "Consistency of BM". Choices were: "Formed/normal, loose/diarrhea, constipation/hard, putty like, resident not available resident refused and not applicable."

There were no bowel movements recorded from 07/11/2016 until 07/17/2016 when one medium, loose/diarrhea stool was recorded at 00:26 (12:26 a.m.) on 07/17/2016. From 07/25/2016 until 07/28/016 no bowel moments were recorded until 21:01 (9:01 p.m.) when one formed/normal stool was recorded on 07/28/2016. From 07/30/2016 through 08/03/2016 no bowel movements were recorded.

A meeting was held with the DON (director of nursing) and the administrator on 08/02/2016 at approximately 4:00 p.m. The above information was reviewed.

On 08/03/2016 a new order, handwritten by the physician for Colace and Senna was presented to this surveyor. The new order read: "D/C [discontinue] previous orders of 1. Colace 100 mg po BID 2. Senna 8.6 mg po qHS Monday, Wednesday, Friday Hold for loose stools. Start Colace 100 mg po BID Start Senna 8.6 mg 1 po qHS on Monday, Wednesday, Friday. Hold for loose stools." The new order was dated 08/02/2016 at 6:15 p.m.

A meeting was held on 08/03/2016 at approximately 10:30 a.m. with the DON, the administrator, the assistant administrator and the ADON (assistant director of nursing). The new order was discussed. The ADON stated, "24 hour night checks are done by the night shift

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charge nurse...the original order written on July 13 for bowel meds was not taken off." The ADON was asked why if a chart check was done every 24 hours the order dated 07/13/2016 was not noted until discovered by this surveyor on 08/02/2016. She stated, I will check on that." The administrative team was asked for a copy of the facility bowel regimen policy or any standing orders related to bowel management.

On 08/03/2016 at approximately 1:45 p.m., this surveyor went to the unit where Resident #4 resided. LPN #7 was asked if the resident had received his Colace for the day. She stated, "No, it is not here from the pharmacy yet...it is coming from Columbia on the next run." LPN #7 was asked if the facility carried a house stock of Colace or if it was in the stat box. She stated, "No."

On 08/03/2016 at approximately 2:00 p.m. LPN #7 came to the conference room to speak with this surveyor. She stated, "The medications arrived and I gave [name of Resident #4] his Colace."

On 08/04/2016 the ADON left a note for this surveyor that read: "There is no bowel and bladder policy." This was verified with the DON, the administrator and the ADON during a meeting on 08/04/2016 at approximately 2:30 p.m.

No further information was obtained prior to the exit conference on 08/04/2016.

F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	**F-Tag 323** **Criterion #1 – Correction** Resident #1's care plan will be reviewed and updated to reflect

The facility must ensure that the resident

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environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to provide supervision for accidents resulting in harm for two of 27 residents, Resident #1, and 4. In addition, the facility staff failed to provide safety interventions for two of 27 residents in the survey sample, Resident #3 and 7.

1. Resident #1 was not provided supervision in the dining room, which resulted in a fall with facial lacerations requiring twelve sutures resulting in harm.

2. Resident #4 was not provided supervision and safety interventions while in bed, which resulted in a fall with lacerations requiring sutures which constitutes harm. Resident #4 was found by his bedside with a laceration to his left ear and abrasions to his buttocks. He was sent to the emergency and returned with sutures in his ear. During the survey Resident #4 was observed without physician ordered alarms in place, the incorrect alarms in place, and not wearing physician ordered hipsters to prevent hip injuries in the event of a fall.

3. The facility staff failed to ensure appropriate supervision and/or safety devices for the

safety interventions and these will be communicated to the staff. Fall prevention interventions will be documented in the medical record.

Resident #4's care plan will be reviewed and updated to reflect safety interventions and these will be communicated to the staff and to the resident's spouse. Fall prevention interventions are being documented in the medical record.

Resident #3's care plan will be reviewed updated to reflect safety interventions and these will be communicated to the staff. Fall prevention interventions will be documented in the electronic record.

Resident #7's care plan has been reviewed updated to reflect safety interventions include use of alarm and floor mat. Fall prevention interventions will be documented in the electronic record.

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prevention of falls for Resident # 3; Resident # 3 was identified by the facility as being at high risk for falls, and as having a history of falls.

4. Resident #7 was not provided safety interventions for accident prevention. Resident, # 7, did not have a fall mat by the bedside, and did not have the hipsters on to prevent hip injury from a fall.

The findings include:

1. Resident #1 was not provided supervision in the dining room, which resulted in a fall with facial lacerations requiring twelve sutures resulting in harm.

Resident # 1 was admitted to the facility on 2/11/16, with but not limited to the following diagnoses: dementia (memory loss) without behaviors, hypertension (high blood pressure), and type 2 diabetes (abnormal blood sugars). The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/9/16 was a quarterly assessment. The resident was assessed as being having short and long-term memory impairments and moderately impaired in decision-making skills. Section G for transfers assessed the resident as 3/3, extensive assistance with two person physical assist. Ambulation the resident was assessed as 4/2, total dependence with the assist of one person.

On 8/2/16 at approximately 3:00 p.m., Resident #1's clinical record was reviewed. A nursing note was documented to include the following: "7/20/16 Note Text: At 4:36pm writer was called by another nurse saying that resident in [room #]

Criterion #2 – Other Potential
Current residents will have their care plans reviewed to ensure that interventions are in place to minimize recurrence; falls will be investigated and the resident's plan of care will be reviewed and revised based on the investigation. Care plan interventions will be communicated to the direct care staff for implementation and carryover.

Criterion #3 – System Change
Licensed nursing staff will complete fall risk assessments on admission/re-admission and when a resident experiences a significant change.

The interdisciplinary team was educated by a long term care consultant on completing fall investigations.

The interdisciplinary team will be re-educated on developing and revising resident centered care plans including individualized

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F 323	Continued From page 42 fell. Observed resident on the floor face down with laceration on her forehead. Site was cleaned...Resi was sent to ER [emergency room] via 911 per MD [doctor/physician's] orders..." "7/20/16 22:43 [10:23 p.m.] Resident returned from ER via stretcher...she returned with twelve stitches on her left forehead and with order sutures out 5-7 days...[sic]." A fall assessment dated 2/11/16, 2/18/16 and 5/20/16 assessed the resident as being a 55 (High Risk 45 and higher) for falls. A Fall Care plan initiated and revised on 4/25/16 was documented to include the following: "Focus: The resident had an actual fall /at risk for further falls R/T [related to] Gait/balance problems and unaware of safety needs...Intervention/Tasks: Staff will close dining room when not in use by resident...Staff to frequently check on resident..." On 8/3/16 at approximately 7:47 a.m., the director of nursing was interviewed regarding an investigation related to the fall. The director of nursing presented to this Surveyor a copy of the "Fall Investigation." Upon review of the Fall Investigation, the following was documented: "7/20/16...Description of Current Fall Date 7/20/16: 4:36 p.m. Location: D-Dining room...Fall within the past [3 months was marked]..Conditions: Unsteady Gait, Incontinence, Short-term memory loss...Environmental /Situational Conditions...Attempts to walk without assistance...Impact from Fall...Laceration to her left side forehead...Staff interviews [CNA, certified nursing assistant caring for Resident #1] Per staff she stated "I took another resident to the	F 323	approaches to minimize falls. As appropriate care plan interventions to minimize falls, will be linked to the electronic medical record for documentation of administration of the interventions by staff. The CNA staff will be re-educated on documenting carry over of fall prevention interventions from the resident's care plan in the electronic medical record. Nursing staff on all shifts will be re-educated on purposeful rounding. Residents who have experienced a fall will be discussed the next morning meeting by the clinical team to begin investigation and ensure that interventions have been put in place. During the weekly "CAAR" meeting, documentation will be reviewed to ensure that the investigation has been completed and determine if additional interventions need to be implemented.	

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F 323	Continued From page 43 bathroom and left the other resident in the dining room. Resident was sitting in her wheelchair...Care Plan Review. Current Plan is effective to prevent recurrent falls/injury...Frequent staff check. The staff, who was involved in the incident, provided Witness Statements, which were attached to the Fall Investigation Report. The Witness Statements were reviewed to include the following: A. "I was coming up I saw the nurse runing [sic] towards the dining room. I following the nurse I saw a Resident on the Floor...." B. "I was in the Dinning Room I told [CNA named] I going to get something in my car I will be back...." C. "Writer was called by another nurse to the dinning say resident in [room number] fell. Observed resident on the floor face down with laceration on her forehead. Assign CNA told me that another CNA was in the dinning room who left without telling somebody else to sit with residents...." On 8/3/16 at approximately 7:47 a.m., the director of nursing (DON) was interviewed regarding the above incident and investigation. The DON was interviewed and asked if the Resident was left unattended in the dining room. The DON stated, "Yes." When interviewed and asked if the resident should have been left unattended, the DON stated, "No." This Surveyor requested to speak with the CNAs involved in the incident, the CNAs were not	F 323	**Criterion #4 – Monitoring** The Unit Manager and/or designee will audit 3 new admissions / re-admissions weekly to ensure that the fall risk assessment has been completed and interventions put in place to minimize fall. Variances will be investigated, staff re-educated and interventions put into place as needed. The Unit Manager and/or designee will conduct weekly observational audits of 3 residents per shift per unit to validate that the planned fall interventions are in place. If variances are identified responsible staff will be re-educated and the planned interventions put into place. These weekly audits will be given to the DON/ADON for tracking of trends and a summary of the weekly audits will be provided to the QA Committee.	

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available for interview during the time of the Survey.

No further information was provided during the course of the survey as to why the resident was left unattended in the dining room.

2. Resident #4 was not provided supervision and safety interventions while in bed, which resulted in a fall with lacerations requiring sutures which constituted harm. Resident #4 was found by his bedside with a laceration to his left ear and abrasions to his buttocks. He was sent to the emergency and returned with sutures in his ear. During the survey Resident #4 was observed without physician ordered alarms in place, the incorrect alarms in place, and not wearing physician ordered hipsters to prevent hip injuries in the event of a fall.

Findings were:

Resident #4 was admitted to the facility on 03/24/2015 with the following diagnoses, but not limited to: Unspecified mood disorder, hypertension (high blood pressure), depressive disorder, chronic ischemic heart disease (heart problems), history of falling and a traumatic brain injury.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/25/2016. Resident #4 was assessed as having difficulty with both long and short term memory, as well as being moderately impaired with daily decision making skills.

Criterion #5 – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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The paper/hard chart and electronic medical record were reviewed on 08/02/2016. The following orders were present on the current physician order sheet: "Bed and Chair alarm-Check for placement and function every shift. Hipster to be worn at all times except for perineal care." The care plan was reviewed. A problem area listed was: "Resident have [sic] had actual falls with no injury/potential for further falls R/T [related to] unsteady gait and being non compliance [sic] (intentionally transferring himself on the floor) and confusion." Interventions included but were not limited to: "Bed alarm to alert staff; Hipster to minimize fall related injury; Wheel chair alarm to alert nurse (utilize pressure pad).

On 08/02/2016 at approximately 3:00 p.m., Resident #4 was observed sitting up in his wheelchair eating a snack. His private sitter was in the room. There were no alarms visible on his wheelchair. The sitter was asked if the resident had any alarms in use. She stated, "He has one, I will put it on now." She then went to a chest of drawers in the room and located a tab alarm lying on the top. The cord for the alarm was wrapped around the alarm box. The sitter was asked if she normally used the alarm. She stated, "No, but I will put it on him now." The sitter was asked if Resident #4 was wearing his physician ordered hipsters. She stated, "No...they were soiled with poopie and I sent them to laundry." The sitter was asked when they were sent to be cleaned. She stated, "Yesterday." She was asked if he had more than one pair. She stated. "No, just the one."

On 08/03/2016 at approximately 8:30 a.m.,

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Resident #4 was observed in the dining room. He was sitting in the middle of the room, dressed in shorts and a t-shirt. There was a tab alarm on his chair and hooked to the back of his shirt. A CNA (certified nursing assistant) in the dining room was asked if he was wearing his hipsters. She stated, "I'm not his aid today but I will take him to his room and we can check...breakfast isn't here yet." She then took Resident #4 to his room." Once in his room the CNA stated, "I don't feel them on him." The private sitter was in his room. She had a pair of hipsters in her hand. They were new and still in the wrapper. She stated, "I just got them [hipsters]...his wife does his laundry and his are at home...I will put the new ones on now."

The progress note section of the clinical record was reviewed on 08/03/2016. Observed was a note dated 10/19/2015 which read: "Resident sustained a fall on 10/17/2015 without injury...Was noted to have gotten up from wheelchair and fell on to buttocks. Hipsters were on, resident had a wheelchair alarm that appeared to have had the string removed (where it was attached to resident). Resident switched to pressure alarm as intervention to prevent tampering.

Also observed in the progress notes were the following entries:
" 12/3/2015 07:57 [7:57 a.m.] This writer assessed pt [patient]. Pt observed with laceration to the left ear (pinna) measuring 5 X [by] 1 cm [centimeter]. Pressure applied to site and wrapped with bandaid. Multiple abrasion noted on pt buttocks. Supervisor made aware. On call MD [medical doctor] notified. Pt alert and verbally responsive, hand grasp are strong bilaterally. Pt

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transferred to [name of hospital] via 911."

"12/03/2016 14:00 [2:00 p.m.] ...Resident had a fall this morning, was found in his room by his bedside, sustain laceration to Lt [left] ear and abrasions to buttocks. Resident was D/C [discharged] to the hospital for evaluation. Resident return back from Hospital...New orders for Keflex prophylaxis, to remove dressing from Lt ear laceration in 1 wk [week], treatment to abrasion on buttocks. Bed and W/C [wheelchair] alarm.. MD and RP [responsible party] notified."

The review showed no evidence that interventions were in place to prevent Resident #4 from falling.

Also observed in the clinical record were discharge instructions from the hospital which included the following information:

"Laceration was not repaired completely because pt was combative. Dressings, applied, will need to stay in place for 1 week. Discharge Prewritten Instructions: Laceration Care, Sutured Wound Care."

On 08/03/2016 a fall investigation was requested for the fall on 12/03/2016. At 2:45 p.m., the ADON (assistant director of nursing) stated, "We cannot find the fall investigation for the fall in December...I am pretty sure we did one, I was the unit manager at the time...the DON [director of nursing] that was here then is gone now." The ADON was asked if Resident #4 had sutures placed in his ear at the time of the fall. She stated, "I don't think so."

The wound care specialist notes were reviewed.

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The note dated 12/16/2015 contained the following information: "Assessment and Plan: WOUND OF THE LEFT EAR FACE-NO CHANGE...REMOVED SUTURES"

The above note was shown to the ADON. The ADON was asked if she knew how many sutures Resident #4 had in his ear. She looked through the clinical record and reported that she had been unable to locate that information.

On 08/04/2016 at approximately 1:15 p.m., this surveyor went to Resident #4's room with the unit manager to determine what type of alarm Resident #4 had in place. The care plan entry for the pad alarm was shown to the unit manager. She accompanied this surveyor to the room. Resident #4 was lying on his bed. The unit manager lifted up the edge of the fitted sheet, revealing a green pressure alarm on the bed. The unit manager was asked where the alarm box was as this surveyor had observed the private sitter transfer the resident from his bed to his wheelchair earlier in the day and had not heard an alarm sound. The private sitter and the unit manager located the cord coming from the pad alarm and pulled it out from under the bed. The cord was not attached to anything. The private sitter was asked if the alarm ever sounded when she transferred the resident. She stated, "No, it is not attached to anything." The unit manager was asked if the alarm box had fallen under the bed. She stated, "No." She then looked in the drawer of the bedside table. She located an alarm box in the back of the drawer and a small pad alarm still in the wrapper and not previously used. The wheelchair was sitting at the bedside. There was not a pad alarm in the seat of the wheelchair. This surveyor pointed to

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the seat and asked if the pad alarm located in the drawer was supposed to be the one on the wheelchair. The unit manager stated, "Yes." The unit manager was asked why the pad alarm on the bed was not attached to an alarm box and why the pad alarm in the drawer had not been used on the chair. She stated, "We need to educate." She was asked who was checking the placement and function of the alarms every shift as ordered by the physician. She again stated, "We need to educate."

The ADON came to the conference room at approximately 1:30 p.m. and stated, "I just went up to [name of Resident #4]...he has the alarms in place now."

The above information was shared with the DON (director of nursing), the ADON and the administrator during a meeting on 08/04/2016 at approximately 2:30 p.m. Concerns were voiced that Resident #4 did not have physician ordered safety devices in place: hipsters, and alarms. Also discussed was the identification of possible harm due to his fall in December with resulting suture placement.

No further information was obtained prior to the exit conference on 08/04/2016.

3. The facility staff failed to ensure appropriate supervision and/or safety devices for the prevention of falls for Resident # 3; Resident # 3 was identified by the facility as being at high risk for falls, and as having a history of falls.

Findings include:

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Resident # 3 was admitted to the facility on 09/08/15 originally, with the most current readmission on 07/06/16. Diagnoses for Resident # 3 included, but were not limited to: dementia, visual disturbances with macular degeneration (very poor vision), difficulty walking, weakness, and a history of falls.

The most current full MDS (minimum data set) was a significant change assessment dated 07/12/16, which assessed the resident as having a cognitive score of "7", indicating the resident had severe impairment in daily decision making skills. The resident was also assessed on this MDS as having 2 or more falls with injury (except major) and as having 1 fall with major injury. The resident was additionally assessed as not ambulating during the look back period and as requiring extensive to total dependence on staff for all ADL's (activities of daily living). The resident additionally triggered for cognition, communication, vision and falls in the CAAS (care area assessment summary) section of this MDS. In section G0300. Balance During Transitions and Walking of this MDS, the resident was coded as 'Activity did not occur' for moving from seated to standing position, walking, turning around and facing the opposite direction while walking, and as 'Not steady, only able to stabilize with human assistance' for moving on and off the toilet and surface to surface transfers.

The most recent quarterly MDS assessment was reviewed for comparison. This MDS assessment dated 06/02/16 (just prior to the fall with injury on 07/03/16) documented Resident # 3 as having a cognitive score of "7", again indicating the resident had severe impairment in daily decision

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making skills. This MDS additionally assessed the resident as requiring limited assistance for transfers (bed mobility/transfers) and ambulation (in room/corridor), with at least one staff for guided maneuvering and physical assistance. The resident was coded on this MDS as requiring extensive assistance from at least one staff person for dressing/toileting/hygiene and bathing. In section G0300. Balance During Transitions and Walking of this MDS, the resident was coded as 'Not steady; only able to stabilize with human assistance' for moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet and surface to surface transfers.

During clinical record review on 08/02/16 through 08/04/16, Resident # 3's nursing notes were reviewed. The following was revealed.

12/12/15 timed 11:03 a.m. "...observed on floor on buttocks..."

01/02/16 timed 2:14 p.m. "...sitting on the hallway [sic] with legs bend [sic] and his cane with him..."

02/14/16 timed 8:27 a.m. "...observed in his room sitting in his buttock [sic] close to his bed...floor clean and dry noted wearing plastic sandal with one pair on and the other off [sic]..."

04/01/16 timed 5:02 p.m. "...sitting in bathroom at 11:00 am...legs got weak...helped back to his feet..."

05/06/16 timed 1:34 p.m. "...always in room occasionally takes a walk to dining room or nursing station when needed assistance [sic]..."

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05/21/16 timed 10:37 p.m. ".. at 7:00 pm heard a big sound.. found him [resident] lying on his right lateral side on floor between his bed and his roommate...no injury..."

05/23/16 timed 9:49 p.m. "...Resident found on floor...no injury..."

06/03/16 timed 11:54 p.m. "...denies any post fall pain, gait remains unsteady with ambulation care provided with assist including accompanying resident to and from bathroom fall precautions maintained..."

06/06/16 timed 4:18 p.m. "...Resident is forgetful, needs constant encouragement and reminders to call for assist [sic] with needs..."

06/08/16 timed 12:27 a.m. "...resident has unsteady gain...continues on monitoring for falls..."

06/09/16 timed 10:02 p.m. "...confused...encourage resident to push the call for help to get out of bed..."

06/21/16 timed 2:22 p.m. "Resident has a history of not wearing proper shoes/socks when ambulating. During this review period there were not reports of resident being non-compliant. Will continue to monitor..."

No other information or documentation could be located throughout the resident's clinical record regarding the resident not wearing appropriate shoes and/or socks.

06/21/16 timed 2:23 p.m. "...resident continues to exhibit cognitive impairment r/t [related to] dx

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[diagnoses] of dementia...A&O [alert and oriented] to name but presents with confusion, resident has two certifications stating that he is unable to make medical decisions. ."

A nursing note dated 07/03/16 was created at 5:31 p.m. and had an 'effective' time as 2:30 p.m. documented: "Resident complained of pain on his left knee and left leg...no swelling noted but bruises noted on his right inner thigh and upper back. Resident able to acknowledge that he fell, but unable to verbalized [sic] how the incident occurred...medicated with Tylenol 650 mg [milligrams]...MD [medical doctor] notified of the incident...order for an x-ray to the femur, left knee, and tibia and fibula..."

07/03/16 timed 4:30 p.m. "PRN [as needed] Tylenol given at 10 Am [sic]..."

07/03/16 timed 5:48 p.m. "RP [responsible party]...made aware..."

07/03/16 timed 7:45 p.m. "PRN administration was effective..."

07/04/16 timed 1:13 a.m. "Res [resident] alert and verbally responsive. C/O [complained of] left hip pain, medicated with PRN Tylenol, help [sic]..X-ray done in the AM. Result came with the impression on no (L) [left] femoral shaft fracture but appear [sic] to be fracture involving the (L) femoral neck. MD made aware...order for x-ray of the hip to R/O [rule out] FX [fracture] of femoral neck. X-ray done and result came back with impression of acute fracture of the left femoral neck. MD made aware of new x-ray report, order given by MD to transfer res to ER [emergency room]. Res transferred to [initials of hospital] ER

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via 911. RP made aware. "

07/04/16 timed 8:19 a.m. "Resident transferred to hospital..."

07/06/16 timed 2:06 a.m. "...returned from hospital via stretcher this evening...able to move (R) [right] leg but can slightly move (L) [left] injured (FX) [fractured] leg...Assessment by this writer reviled [sic] large (R) inner thigh bruise, and bruise on the buttock, abrasion on (L) upper back and redness on the sacral area...remains in bed..."

On 08/02/16 at 4:10 p.m., in a meeting with the survey team, the DON [director of nursing] and administrator were asked for the resident's care plan and investigation regarding the fall with injury.

Resident # 3's fall assessments were then reviewed.

A fall assessment dated 03/15/16 documented: "..HISTORY OF FALLING- yes...AMBULATORY AID- uses crutches, cane or walker...GAIT-WEAK (stooped but able to lift head without losing balance-steps are short, resident may shuffle...MENTAL STATUS-Overestimates or forgets limits...SCORING-Click Save. The score and category will appear in the header of the assessment. Morse Fall Scoring: High Risk 45 and higher
Moderate Risk 25-44 Low Risk 0-24..." Resident # 3's fall risk category on this fall assessment was documented as "High Risk for Falling" and as having a fall risk score of "80."

A fall assessment dated 05/27/16 [just prior to the

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fall on 07/03/16] documented: "..HISTORY OF FALLING- yes...AMBULATORY AID- uses crutches, cane or walker...GAIT-IMPAIRED (difficulty rising from chair, uses chair arms to get up, bounces to rise, keeps head down when walking, watches the ground, grasps furniture, person or aid when ambulating. Cannot walk unassisted)...MENTAL STATUS-Overestimates or forgets limits...SCORING-Click Save. The score and category will appear in the header of the assessment. Morse Fall Scoring: High Risk 45 and higher Moderate Risk 25-44 Low Risk 0-24..." Resident # 3's fall risk category on this fall assessment was documented as "High Risk for Falling" and as having a fall risk score of "90 "

A vision consult dated 10/5/15 was reviewed for Resident # 3. The vision consult documented: "...bilateral wet AMD [age related macular degeneration]...poor prognosis...symptoms [for] 2-3 years..."

The resident's CCP (Comprehensive Care Plan) was presented and reviewed. The CCP documented: "...09/09/15 [date initiated] Resident is dependent on staff...The resident needs assistance/escort to activity functions...09/09/15 [date initiated] The resident has an ADL self-care performance deficit r/t dementia...Encourage the resident to use bell to call for assistance...09/09/15 [date initiated] The resident has impaired cognitive function/dementia or impaired thought processes r/t dementia, difficulty making decisions...Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion...09/09/15 [date initiated] The resident has a communication problem r/t hearing deficit...Communication: ...Do not rush...use

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simple, brief, consistent words...Monitor for/record...decline in cognitive status, mood, decline in ADL...09/09/15 [date initiated] Resident had a fall and he is at risk for further falls r/t confusion, deconditioning, vision complications...Anticipate and meet resident's needs. Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed, 04/01/16 [date initiated] Frequent cueing/supervision and monitoring by the staff due to resident's deconditioning status...12/23/15 [date initiated] Remind resident to use call light when attempting to ambulate, transfer or toilet use...05/27/16 [date initiated] Staff will encourage resident to have proper and safe foot wear on at all times when OOB [out of bed]...09/09/15 [date initiated] The resident has impaired visual function r/t blurred vision...Arrange consultation with eye care practitioner as required, monitor /document /report PRN any s/sx [signs or symptoms] of acute eye problems: Change in ability to perform ADLs, decline in mobility..."

On 08/03/16 at 10:30 a.m., the survey team again met with the DON and administrator and they were made aware of concerns regarding the above information. The fall investigation for Resident # 3's fall on July 3 was again requested.

Resident # 3's fall investigation was presented on 08/03/16 at approximately 2:00 p.m. The fall investigation documented: "FALL INVESTIGATION 07/03/16 DIAGNOSES: Anemia, a-fib [atrial fibrillation], DM [diabetes], Hx [history] of falls...Description of current fall: 07/03/16 2:56 p.m. Location: resident room History-has resident had a fall within the past month, 3 months, 6 months [3 months was

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marked for Resident # 3] Conditions: Unaware of safety hazards, history of falls within past 6 months...environmental/situations conditions: ambulating without needed help...Impact from fall: bruise [only result marked]...describe what the resident was doing before the fall; describe the resident's behavior prior to the fall. (write in box below) Resident reported to staff that he fell [no other information was documented]...CARE PLAN REVIEW: Recommendations to minimize recurrent falls (write in box): Resident was transported to the hospital for treatment due to s/p [status post] xrays reports fracture hip [sic]..." No other information was included in this investigation.

X-ray documents were then reviewed for Resident # 3.

An x-ray dated 07/03/16 and timed 3:19 p.m. documented: "...no evidence of left femoral shaft fracture. There does, however appear to be an acute fracture involving the left femoral neck..."

An x-ray dated 07/03/16 and timed 4:25 p.m. documented: "...left knee show no fracture or dislocation..."

An x-ray dated 07/03/16 and timed 4:25 p.m. documented: "...left tibia and fibula reveal no fracture..."

An x-ray dated 07/03/16 and timed 8:03 p.m. documented: "...left hip show an acute...left femoral neck fracture. The intertrochanteric area and femoral shaft are displaced superiorly and laterally..."

At approximately 1:30 p.m., the DON, ADON

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(assistant director of nursing), and administrator were made aware of concerns regarding the above. The DON was asked if there was any additional information/documentation regarding Resident # 3's fall with significant injury. The DON voiced, only what was in the nursing notes and the fall investigation presented. The DON was made aware of multiple concerns with lack of information/documentation in the investigation. The investigation did not provide any details regarding the fall, specifically how the resident was found and by whom, what the actual time of the fall was, what were the circumstances surrounding the fall, and that there were no employee/witness statements of any kind from anyone. The facility staff were also made aware that this resident had been identified as a high fall risk by the facility with no new or updated interventions were put in place in an attempt to decrease the probability of the resident falling again after the resident had multiple falls in the past without injury. The DON, ADON and administrator were made aware that the interventions in place for Resident # 3 may not have been appropriate, such as encouraging the resident to call for assistance when the resident had been assessed with severe cognitive impairment and had additionally been assessed as requiring assistance from staff for ambulating, toileting and dressing. The DON was asked what 'fall precautions' meant. The DON voiced that it means to have the call bell in reach, the bed in low position, items the resident uses frequently close and in reach and further voiced that those should be in place all the time.

The DON voiced that she would look for additional information regarding the above. A policy was requested on falls, unwitnessed falls,

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falls with injury.

A fall policy was presented on 08/04/16 at approximately 1:00 p.m. The policy documented "Policy and Procedure Fall prevention and risk assessment...to provide an environment that is safe and that minimizes the potential for resident injury due to falls...Falls are a common source of injury and death among the elderly. Early identification of risk factors and staff intervention can reduce the risk of falls; investigation and analytics post fall can identify other risk factors and provide information that may serve in planning interventions to prevent recurrence...internal risk factors...resident's physical and cognitive health, as well as functional status...external factors...medication side effects, the use of assistive devices or appliances and restraints...Fall: any event in which the resident comes to rest unintentionally upon the ground, floor or other lower level...rolls from a bed, the resident is considered to have fallen even if the event is not witnessed...SPECIFIC PROCEDURE/REQUIREMENTS: All residents will be assessed for fall risk, upon admission, quarterly and upon any significant change...the results of the fall risk assessment will be used in identifying immediate measures to be instituted to prevent the resident from falling...providing a low bed with bedside mats...bed or chair alarms...perimeter definers...adaptive call bell...non skid slippers or shoes during transfer...medication regimen review...rearranging the resident's room to reduce trip hazards and obstacles...providing specific toileting schedule or bedside commode...Risk factors and fall prevention measures for individual residents will be documented on the residents

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comprehensive care plan and communicated to the direct care staff for implementation...Any resident who falls will be immediately assessed for potential injury, and treated as necessary, the nurse responsible for the resident will document the circumstances surrounding the fall in the medical record. The nurse will take any immediate measures necessary to prevent a recurrence of a fall...will be investigated to identify internal and external factors...circumstances within or beyond the facility's control in preventing the fall...the result of the investigation will used...in identifying and care planning additional interventions..."

Resident # 3 was observed in his room on 08/03/16 at 7:50 a.m., the resident was laying flat in his bed, two 1/2 siderails in the up position were observed with the call bell in reach. No fall mats were observed, no alarm of any kind was observed. The resident had a cane located in one corner of his room and a rolling walker located in other.

Again on 08/04/16 at 2:30 p.m., the administrator, DON and ADON were made aware of multiple concerns in a meeting with the survey team. The DON voiced that the facility had no additional information or documentation regarding Resident # 3's fall with injury.

No further information or documentation was presented prior to the exit conference on 08/04/16 at 3:30 p.m.

4. Resident # 7 did not have a fall mat at the bedside while in bed, and did not have hipsters (a padded shield worn to protect the hip area) on for

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the prevention of an injury in case of a fall

Findings include:

Resident # 7 was admitted to the facility with diagnoses to include, but not limited to: dementia with behaviors, stroke, depression, high blood pressure, low thyroid function, and a history of falls.

The most recent MDS (minimum data set) was a quarterly review dated 7/28/16 and had Resident # 7 coded with severe impairment in cognition with a total summary score of 07 out of 15.

On 8/2/16 at 9:55 a.m. Resident # 7 was observed laying in bed with his eyes closed. The area around the bed was free from clutter, and the bed was in the lowest position. No other items were observed on the floor.

The clinical record was reviewed 8/2/16 at 10:00 a.m. The current pos (physician order summary) for August 2016 included a "General Orders" section which documented "Floor mat when in bed." The care plan was then reviewed. The care plan included "Goal: The resident will be free of fall related injury through the next review date." The start date for the goal was 10/23/15. A revision date of 4/15/2016 was included with the goal. Interventions for the fall prevention included "Floor mat while resident in bed to minimize fall related to injury. Frequent checks by staff... Hipsters in place to prevent further injury....."

On 8/2/16 Resident # 7 was observed in bed at 10:10 a.m , and again at 1:45 p.m. in bed. There was not a floor mat beside the bed.

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On 8/2/16 at 1:50 p.m. CNA (certified nursing assistant) # 1 was identified as the staff caring for Resident # 7. CNA # 1 was asked about the floor mat. CNA # 1 stated "He does not have one. It has been two or three months since he's had a mat. He doesn't use it anymore." The CNA was also asked about the resident's use of hipsters, and she stated she did not know about that.

On 8/2/16 at 2:05 p.m. LPN (licensed practical nurse) # 3, who was the nurse manager for the unit, was asked about the floor mat and hipsters for Resident # 7. LPN # 3 and this surveyor went to Resident # 7's room, knocked, and given permission to enter. LPN # 3 looked around the resident's room, but the floor mat was not located. LPN # 3 then asked the resident if she could check him to see if his hipsters were on. Resident # 7 said "Yes" and LPN # 3 then checked the resident. LPN # 3 then looked at this surveyor and stated "They're not on." LPN # 3 was asked where the floor mat and hipsters would be documented by staff as being in place. LPN # 3 was further asked if the hipsters required a physician order. LPN # 3 stated "No, the hipsters are a nursing intervention. The floor mat is usually an order." LPN # 3 further stated the floor mat and hipsters would be documented on the TAR (treatment administration record). LPN # 3 was then made aware of the above conversation with CNA # 1.

On 8/3/16 at 8:30 a.m. LPN # 7 was asked for a copy of the resident's August 2016 TAR for review. LPN # 7 proceeded to look in the electronic system for the TAR. LPN # 3 walked over to ask LPN # 7 what she was looking for, and LPN # 7 told her the TAR for [name of resident]. LPN # 3 then stayed at the computer to

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help LPN # 7. At 8:50 a.m. LPN # 7 told this surveyor "I don't see his name for a TAR." LPN # 3 stated "While a physician order isn't needed, a nursing intervention should be put on the POS so it will generate a TAR for documentation."

On 8/3/16 the medical records staff who had been asked at 8:15 a.m. for a copy of the resident's MAR's (medication administration record) and TAR's for June 2016 to August 2016 presented a copy of the MAR's to this surveyor at 10:15 a.m. and stated "There were no TAR's for the resident."

The administrator, DON (director of nursing), assistant administrator, and ADON (assistant director of nursing) were made aware of the above observations and findings during a meeting with facility staff 8/3/16 beginning at 10:30 a.m.

No further information was provided prior to the exit conference.

F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

F 431

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary

F-Tag 431

Criterion #1 – Correction
Removed all outdated medications and medications without proper labels from refrigerator and mediation care; ordered new meds. Narcotic medication was destroyed according to facility policy

Criterion #2 – Other Potential
An audit of all medication carts and medication refrigerators will be conducted to ensure medications are properly labeled and within date. Variances will be destroyed per facility protocol.

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F 431	Continued From page 64 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review,the facility staff failed to ensure drugs and biological were stored and labeled on two of 3 units, Units 2 and 4. 1. Medications were observed on the medication cart and in the refrigerator in the medication room without a label and date when opened. There were 11 medications that were without label or date when opened. 2. The facility staff failed to ensure narcotic medication was appropriately discarded/disposed of the resident was discharged from the facility.	F 431	**Criterion #3 – System Change** Nursing staff will be re-educated on the facility policy "Medication Monitoring" and the importance of checking medications prior to administration for labels and expiration. Nursing staff will be re-educated on the facility policy for destroying and/or returning to pharmacy expired medications and on destroying narcotics. The DON/ADON will destroy narcotics weekly. **Criterion #4 – Monitoring** SDC and/or designee will check medication carts and refrigerators twice weekly x 2 months to ensure medications are appropriately labeled and have not expired. Variances will be investigated and corrected. Findings from the weekly audits will be given to the DON/ADON for trending of patterns. A summary of the weekly audits will be given to the QA Committee for additional oversight and recommendation.	

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The findings include

1. On 8/2/16 at approximately 1:55 p.m., during observation of medication cart two, on Unit 4, with the medication nurse, who was a registered nurse and will be identified as RN # 5; the following observations were made: 1 vial of Levemir, 1 vial of Lantus, 1 vial of Humalog and 1 vial of Novolog was observed in the medication cart with an open date of 6/21/16. An opened vial of Novolog insulin was observed in the medication cart without an opened date. RN #5 observed the vials of insulin and stated, "The date [on the insulin dated 6/21/16] should be 7/21/16. I think the nurse made a mistake when she labeled the vials of insulin." As for the vial of insulin opened and not dated, RN #5 stated, "The date should be 7/28/16, it was just opened."

On 8/2/16 at approximately 2:00 p.m., medication cart one was observed with the medication nurse, who was a licensed practical nurse and will be identified as LPN #1; the following observation was made: two vials of Novolog and two flex pens (insulin pens) were observed in the medication cart without a date when opened. A vial of Novolog insulin with an open date of 6/26/16 and a flex pen with an opened date of 7/1/16. LPN # 1 observed the vials of insulin and stated, "The expired insulin should have been discarded and the opened vial of insulin should been dated when opened."

On 8/2/16 at approximately 2:00 p.m., during the observation of the refrigerator in the medication room with the unit manager, who will be identified as LPN #8, the following observation was made: An opened vial of Levemir was observed in the refrigerator without a date when opened. LPN #8

Criterion #5 – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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removed the insulin from the refrigerator and stated, "The medication should have been labeled and dated." LPN #1 removed the vial of insulin from the medication cart.

On 8/2/16 at approximately 4:00 p.m., the administrative staff were made aware of the above findings. A copy of the facility's policy regarding "Medication Monitoring" was reviewed to include the following: "...Check expiration date on package and container. No expired medications will be administered to a resident...b. A nurse shall place, a 'date opened' sticker on the medication if one is not provided...Guidelines...4. The beyond use date after initially entering or opening multiple dose vials is 28 days unless otherwise specified by the manufacturer..."

2. The facility staff failed to ensure narcotic medication was appropriately discarded/disposed of the resident was discharged from the facility.

Findings include:

On 08/03/16 at approximately 8:15 a.m., the medication room on the 2nd floor was observed with LPN [Licensed Practical Nurse] # 2. In the locked refrigerator, in a permanently affixed locked box was a box of liquid Ativan. The LPN was asked if this resident was still a current resident, the LPN voiced that she did not know for sure and asked RN [Registered Nurse] # 2. RN # 2 came into the medication room, and looked at the label on the Ativan and voiced, no this resident is no longer here. The RN was then asked when was the resident discharged. The RN voiced that he would have to look to see

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when the resident was discharged.

RN # 2 got on the computer and identified that this particular resident was discharged from the facility on 07/21/16 [Thursday]. RN # 2 was asked who is responsible for checking to ensure that medications are returned to the pharmacy after discharge. The RN voiced that narcotics are not returned to the pharmacy, they are destroyed by two people. The RN was asked, which two people. The RN voiced, the DON [director of nursing] and another nurse. RN # 2 was asked how often is the medication room checked for this. The RN voiced, periodically and further voiced, it's counted everyday. RN # 2 was asked that if the medication is counted everyday, someone should have recognized that this resident is no longer here and the medication should have been either sent back to pharmacy or destroyed. RN # 2 voiced, yes should have counted and recognized and destroyed.

On 08/03/16 at approximately 11:45 a.m., the DON [director of nursing] and the ADON [assistant director of nursing] was made aware of the above information. The DON voiced that she and the ADON are the ones to check the medication rooms and destroy those type of medications, when a resident is discharged from the facility. The DON was asked how often is that done. The DON voiced, weekly. A policy was requested for returning or disposing of narcotic medications after resident discharge.

On 08/03/16 at 2:15 p.m., the DON voiced that the facility does not have a policy on disposal of narcotics after resident discharge. The DON was asked if the medication rooms are checked weekly by the DON and ADON, why was it

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F 431

missed. The DON voiced, that she was not sure how it got missed.

No further information or documentation was presented prior to the exit conference on 08/04/16 at 3:30 p.m.

F 502 483.75(j)(1) ADMINISTRATION

F 502

SS=D

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to obtain physician ordered labs in a timely manner for one of 27 residents in the survey sample: Resident # 7. A physician ordered TSH (a blood test for thyroid function) was not done as ordered.

Findings include:

Resident # 7 was admitted to the facility with diagnoses to include, but not limited to: dementia with behaviors, stroke, depression, high blood pressure, low thyroid function, and a history of falls.

The most recent MDS (minimum data set) was a quarterly review dated 7/28/16 and had Resident # 7 coded with severe impairment in cognition with a total summary score of 07 out of 15.

The clinical record was reviewed 8/2/16 at 10:00

F-Tag 502

Criterion #1 – Correction
Resident #7's physician was notified that the TSH ordered for 7/4/16 was not obtained until 7/16/2016.

Criterion #2 – Other Potential
A 100% audit of current residents will be completed to ensure that all labs ordered since 8/5/2016 have been obtained as ordered by the physician. If variances are found the physician will be notified and clarification obtained for the next step.

Criterion #3 – System Change
Nurses will be educated to enter all new labs order on TAR and enter in the lab requisition form. If a lab is not obtained per physician order, the physician will be contacted for further instructions on obtaining the lab.

Unit Managers and nursing supervisory staff will be reeducated in the facility's lab tracking system. This system monitors when labs are due, when completed, when results are returned to the facility and physician notification.

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a.m. A physician order dated 6/13/16 documented "TSH level in 3 weeks." (The lab would be due 7/4/16). A review of the lab section was then performed, but a lab result for a TSH dated 7/4/16 was not located.

On 8/2/16 at 10:30 a.m. the DON (director of nursing) was asked for assistance in locating the lab result for 7/4/16.

On 8/2/16 at 11:00 a.m. the ADON (assistant director of nursing) presented this surveyor with a copy of a TSH lab result dated 7/16/16. The ADON stated "I could not find any progress notes addressing the lab for 7/4/16; it wasn't done so we did it 7/16/16." This surveyor asked if there was a physician order for the lab done 7/16/16. The ADON stated "There was no order for the lab 7/16/16."

On 8/3/16 beginning at 10:30 a.m. during a meeting with staff, the DON, ADON, and administrator were made aware of the above findings.

No further information was provided prior to the exit conference.

F 502

Criterion #4 – Monitoring
The night supervisor will audit 5 records per unit weekly x6 weeks and then every other week x2 months to ensure that ordered labs have been obtained per physician order. Variances will be investigated and reported to the DON/ADON for tracking of trends. A summary of the weekly audits will be provided to the QA Committee for additional oversight and recommendation.

Criterion #5 – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.

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.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record

F 504

F-Tag 504
Criterion #1 – Correction
Resident #7's physician has been made aware of the July and August TSH lab results.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF ARLINGTON, LLC	1785 SOUTH HAYES STREET ARLINGTON, VA 22202

(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 504	Continued From page 70	F 504		

review the facility staff failed to obtain a physician order prior to obtaining labs for one of 27 residents in the survey sample: Resident # 7 A TSH (a blood test for thyroid function) was obtained without a physician order.

Findings include:

Resident # 7 was admitted to the facility with diagnoses to include, but not limited to: dementia with behaviors, stroke, depression, high blood pressure, low thyroid function, and a history of falls.

The most recent MDS (minimum data set) was a quarterly review dated 7/28/16 and had Resident # 7 coded with severe impairment in cognition with a total summary score of 07 out of 15.

The clinical record was reviewed 8/2/16 at 10:00 a.m. A physician order dated 7/18/16 documented "TSH level in 3 weeks." (The lab would be due 8/8/16).
A previous physician order dated 6/13/16 documented "TSH level in 3 weeks." (The lab would have been due 7/4/16). A review of the lab section was then performed, but a lab result for a TSH dated 7/4/16 was not located.

The DON (director of nursing) was asked 8/2/16 at 10:30 a.m. for assistance in locating the lab result for 7/4/16.

On 8/2/16 at 11:00 a.m. the ADON (assistant director of nursing) presented this surveyor with a copy of a TSH lab result dated 7/16/16. The ADON stated "I could not find any progress notes addressing the lab for 7/4/16; it wasn't done so

Criterion #2 – Other Potential
A 100% audit of current residents will be completed to ensure that all labs ordered since 8/5/2016 have been obtained as ordered by the physician. If variances are found the physician will be notified and clarification obtained for the next step.

Criterion #3 – System Change
Nurses will be educated to enter all new labs order on TAR and enter in the lab requisition form. If a lab is not obtained per physician order, the physician will be contacted for further instructions on obtaining the lab.

Unit Managers and nursing supervisory staff will be reeducated in the facility's lab tracking system. This system monitors when labs are due, when completed, when results are returned to the facility and physician notification.

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F 504	Continued From page 71 we did it 7/16/16." This surveyor asked if there was a physician order for the lab done 7/16/16. The ADON stated "There was no order for the lab 7/16/16. On 8/3/16 at 7:45 a.m. during a continued review of the clinical record, it was noted a physician order dated 8/2/16 at 8:40 p.m. for "...TSH in AM 8/3/16." During a meeting with facility staff 8/3/16 beginning at 10:30 a.m. the DON was asked about the lab result for 7/16/16, and about the order for the lab to be done today (8/3/16). The DON stated "Since the lab wasn't done 7/4/16, we did the lab 7/16/16 when we realized it was missed." The DON was asked if the lab drawn 7/16/16 had been done for the lab missed 7/4/16, why was the lab to be done today? The DON stated "Because we didn't get the lab on 7/4/16." The DON was then asked if there was an order to cover the lab drawn 7/16/16, and she replied "No". The DON was then asked again that per the order written 7/18/16 for a lab that would be due 8/8/16, why a lab was drawn today? The DON did not answer. No further information was provided prior to the exit conference.	F 504	**Criterion #4 – Monitoring** Criterion #4 – Monitoring The night supervisor will audit 5 records per unit weekly x6 weeks and then every other week x2 months to ensure that ordered labs have been obtained per physician order. Variances will be investigated and reported to the DON/ADON for tracking of trends. A summary of the weekly audits will be provided to the QA Committee for additional oversight and recommendation. **Criterion #5** – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.	
F 514 SS=E	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.	F 514	**F-Tag 514** **Criterion #1 – Correction** Resident #7's current electronic record will reflect administration of safety interventions per physician order and care plan. The staff continues to search for Resident #25's MAR/TAR from April.	

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

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to maintain a complete and accurate clinical record for two of 27 residents in the survey sample, Resident # 7 and # 25.

1. The facility did not have TAR's (treatment administration records) for the documentation of safety interventions for Resident # 7.

2. The facility did not have MAR's (medication administration records) or TAR's for the month of April 2016 for Resident # 25.

Findings include:

1. Resident # 7 did not have a TAR for June 2016 to August 2016 for the purpose of documenting safety interventions as being in place.

Resident # 7 was admitted to the facility with diagnoses to include, but not limited to: dementia with behaviors, stroke, depression, high blood pressure, low thyroid function, and a history of falls.

The most recent MDS (minimum data set) was a quarterly review dated 7/28/16 and had Resident

Criterion #2 – Other Potential
Residents with orders related to fall prevention may have potentially been impacted. An audit will be completed on current residents to ensure that ordered fall prevention interventions have been entered correctly into the electronic record for documentation that the interventions are being administered as ordered. Variances will be corrected.

Hard copy records of current residents have been reviewed to ensure that records are complete. The facility protocol for maintaining a complete and accurate medical record and for securing records until they are scanned electronically will be reviewed with department managers and medical records.

Medication administration records are now completed electronically. In the event that a "paper" MAR/TAR must be used, it will be scanned into the electronic medical record.

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7 coded with severe impairment in cognition with a total summary score of 07 out of 15.

The clinical record was reviewed 8/2/16 at 10:00 a.m. The current pos (physician order summary) for August 2016 included a "General Orders" section which documented "Floor mat when in bed." The care plan was then reviewed. The care plan included "Goal: The resident will be free of fall related injury through the next review date." The start date for the goal was 10/23/15. A revision date of 4/15/2016 was included with the goal. Interventions for the fall prevention included "Floor mat while resident in bed to minimize fall related to injury. Frequent checks by staff... Hipsters in place to prevent further injury....."

LPN (licensed practical nurse) # 3, who was the nurse manager for the unit, was asked 8/2/16 at 2:05 p.m. where the floor mat and hipsters would be documented by staff as being in place. LPN # 3 stated the floor mat and hipsters would be documented on the TAR. LPN # 3 further stated "While a physician order isn't needed, a nursing intervention should be put on the POS so it will generate a TAR for documentation."

On 8/3/16 the medical records staff who had been asked at 8:15 a.m. for a copy of the resident's MAR's (medication administration record) and TAR's for June 2016 to August 2016 presented a copy of the MAR's to this surveyor at 10:15 a.m. and stated "There were no TAR's for the resident."

The administrator, DON (director of nursing), assistant administrator, and ADON(assistant director of nursing) were made aware of the above observations and findings during a meeting

Criterion #3 – System Change
Nursing staff will be re-educated in entering orders into the electronic medical record to include physician orders for fall prevention interventions so that staff will document administration of the interventions.

The facility protocol for maintaining a complete and accurate medical record and for securing records until they are scanned electronically will be reviewed with department managers and medical records.

In June 2016, the facility switched from "Paper" medication records to electronic medication administration documentation. In the event that a "paper" MAR must be used on an interim basis, the "paper" MAR will be filed into the electronic record as a document.

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with facility staff 8/3/16 beginning at 10:30 a.m.

No further information was provided prior to the exit conference.

2. The facility staff failed to ensure a complete and accurate record was maintained for Resident # 25, Resident # 25 was admitted to the facility on 04/06/16 and discharged from the facility on 05/08/16, the resident's MARS/TARS (medication administration records/treatment administration records) for the month of April 2016 could not located by facility staff.

Findings include:

Resident # 25 was admitted to the facility on 04/06/16 and discharged on 05/08/16, diagnoses for Resident # 25 included, but were not limited to: Alzheimer's disease (dementia), GERD (gastroesophageal reflux disease), and HTN (high blood pressure).

The most current MDS (minimum data set) was an admission assessment dated 04/12/16 documented the was a 0/0, indicating the resident was severely impaired cognitively.

During a complaint investigation on 08/03/16 and 08/04/16 the resident's closed record was requested for review.

The resident's closed record was presented and reviewed. During the clinical record review the resident's MARs and TARs for the month of April 2016 could not be located. Assistance was requested from the DON (director of nursing) for

F 514

Criterion #4 – Monitoring
Weekly x 6 and then every other week x 2 months, 5 new admissions/re-admissions orders will be validated for accurate entry into the resident's medical record; audits will be conducted by Unit Managers and/or designee and findings given to DON/ADON for tracking of patterns. Variances will be investigated and corrections made as appropriate. An analysis of the weekly audits will be provided to the QA Committee for additional oversight and recommendation.

Weekly x6 and then every other week x 2 months, 5 residents with orders for fall prevention interventions will be reviewed to ensure documentation that fall prevention interventions are being documented as ordered by the physician. Variances will be investigated, staff re-educated as needed. The Unit Manager and/or designee will complete the audits and forward to DON/ADON for analysis of trends/patterns. A summary report of the audits will be provided to QA Committee for additional oversight and recommendation.

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F 514	Continued From page 75 assistance in locating the missing records. On 08/04/16 at 8:00 a.m., the ADON (assistant director of nursing) voiced that the facility was still searching for it and looking in medical records, but voiced that they (the facility) have not been able to locate April 2016 MARs and TARs. No further information or documentation was presented to evidence that the missing clinical records for Resident # 25 had been located and maintained as of the exit conference on 08/04/16 at 3:30 p.m.	F 514	**Criterion #5** – the facility dutifully alleges compliance of these tasks on or before 09/15/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement.	