| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| RIDGECREST MANOR NURSING & REHABILITATION | 157 ROSS CARTER BOULEVARD DUFFIELD, VA 24244 |

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| F 000 | INITIAL COMMENTS | F 000 | F-000 | |

An unannounced Medicare/Medicaid standard survey was conducted 3/14/17 through 3/16/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirement. The Life Safety Code survey/report will follow.

The census in this 120 certified bed facility was 98 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents 1 through 17 and Resident 22) and 4 closed record reviews (Residents 18 through 21).

F 155 SS=D 483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES

483.10
(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).

(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.

This Plan of Correction is submitted as required under State and Federal regulations and statutes applicable to long term care providers. This POC does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this POC does not constitute a deficiency or imply that the scope of severity regarding the deficiency are correctly applied. Please accept this plan of correction as our credible allegation of compliance. Our compliance will be achieved by the dates listed on the POC or no later than 4/21/17.

F 155

F-155 Formulate Advanced Directives

1. Resident #12's Durable Do Not Resuscitate order was signed by his physician on 3/16/17.
2. A review of other resident's Durable Do Not Resuscitate orders have been audited by Social Service staff to validate MD signature on 3/17/17.
3. Social Service Staff were educated on 3/17/17 by the Administrator on completion of Durable Do Not Resuscitate forms including MD signature.
4. Social Service Director will audit weekly x 3 months the Durable DO Not Resuscitate forms for any residents receiving a new DNR order to validate completion of form including MD signature. The results of audits will be monitored monthly x 3 months by the Quality Assurance Performance Improvement Committee for ongoing monitoring and recommendations.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Administrator | 3-28-17 |

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

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(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.

(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

483.24
(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure the Durable Do Not Resuscitate (DDNR) Order was signed by the physician for 1 of 22 residents (Resident #12).

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The findings included:

The facility staff failed to ensure the physician signed the Virginia Department of Health Durable Do Not Resuscitate Order form for Resident #12.

The clinical record of Resident #12 was reviewed 3/14/17 and 3/15/17. Resident #12 was admitted to the facility 7/16/12 and readmitted 1/11/17 with diagnoses that included but not limited to emphysema, chronic airway obstruction, tobacco use, atherosclerosis of the coronary artery, acute MI (myocardial infarction), hypercapneic respiratory failure, pulmonary heart disease, and alcohol dependence.

Resident #12's annual minimum data set (MDS) assessment with an assessment reference date of 1/25/17 assessed the resident with a cognitive summary score of 15 out of 15.

Resident #12's clinical record had a Virginia Department of Health Durable Do Not Resuscitate Order form. The form was dated 1/30/17 and read:

"I, the undersigned, state that I have a bona fide physician patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):
1. The patient is CAPABLE of making an informed decision...
2. The patient is INCAPABLE of making an

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| F 155 | Continued From page 3<br>informed decision..."<br><br>Box 1 was checked and the form was signed by Resident #12. However, the form had not been signed by the physician.<br><br>The surveyor showed the director of nursing the unsigned DDNR on 3/15/17 at 11:50 a.m. and asked if the DDNR was complete. The director of nursing stated "No. It's missing the physician signature."<br><br>The surveyor informed the administrative staff of the above concern during the end of the day meeting on 3/15/17 at 3:15 p.m.<br><br>No further information was provided prior to the exit conference on 3/16/17. | F 155 | | |
| F 226 SS=B | 483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>483.12<br>(b) The facility must develop and implement written policies and procedures that:<br><br>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>(2) Establish policies and procedures to investigate any such allegations, and<br><br>(3) Include training as required at paragraph §483.95,<br><br>483.95<br>(c) Abuse, neglect, and exploitation. In addition to | F 226 | F226 Abuse<br><br>The facility must Screen potential employees for a History of abuse, neglect or mistreating residents.<br><br>1. Employee's # 7 and #14 have had a criminal background check and references completed and placed in their employee file. A copy of current license for employee # 20 was placed in employee file. Reference checks were | |

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the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-

(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.

(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property

(c)(3) Dementia management and resident abuse prevention.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, employee record review, facility document review and the State Code of Virginia, the facility staff failed to implement policies and procedures to prohibit resident abuse by failing to provide evidence that 2 of 20 employees hired within the past year had been screened for a history of abuse, neglect, and/or mistreatment of residents (employee #7 and employee #14), failed to verify professional licenses with their licensing board for 1 of 20 employees (employee #20), and failed to obtain reference checks on 6 of 20 newly hired employees (employee #1, employee #2, employee #5, employee #9, employee #12, and employee #20).

The findings included:

(a) The facility staff failed to obtain criminal background checks in a timely manner, within 30 days of hire, on 2 of 20 employees hired within the past year, employee #7 and employee #14.

completed for Employees #1, #2, #5, #9, #12, and # 20. Files listed will be completed by 3/31/17.

2. A 100% audit of current employee files was completed on 3/23/17 by the Human resources Director.
3. Education for the Human Resource Director on obtaining references and criminal background checks on potential employees was completed by the Administrator on 3/23/17. A log will be kept by the Human Resource Director that will be reviewed by the Administrator to validate completion of references and criminal background checks for all new potential hires.
4. Administrator will audit new hire files to validate completion of references and background checks as each new employee is hired. Results of audits will be reviewed by Quality Assurance Performance Improvement Committee x 3 months for on-going monitoring and recommendations.

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(b) The facility staff failed to verify that 1 of 20 employees hired within the past year had a valid license, employee #20.

(c). The facility staff failed to obtain references on 6 of 20 newly hired employees (employee #1, employee #2, employee #5, employee #9, employee #12, and employee #20).

On 3/16/17 at 7:45 a.m. the surveyor reviewed the facility policy and procedure titled, "Resident Abuse-Policy-This Facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone ...Procedure-A. Screening It is the policy of the Facility to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks. 1) The Facility will do the following prior to hiring a new employee:
a. i. Generally attempt to obtain references from 2 prior employers for an applicant.
iii. Check with applicable licensing and certification authorities to ensure that employees hold the requisite license and/or certification status to perform their job functions and have no disciplinary action as a result of abuse or neglect.
iv. Conduct a criminal background check in accordance with State law and Facility policy.

Reference: State Code of Virginia. "32.1-126.01. Employment for compensation of persons convicted of certain offenses prohibited; criminal record checks required; suspension or revocation of license. Any person desiring to work at a licensed nursing home shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal convictions or any pending

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criminal charges...A nursing home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange."

The surveyor and other #4 reviewed the 20 employee records hired within the past year on 3/16/17 beginning at 7:45 a.m.
During the employee record review the surveyor noted that employee #7, a respiratory therapist (RT), was hired on 6/15/16. The surveyor noted that the criminal background check was not completed within 30 days of the hire date. The surveyor noted that the criminal background check was not done until 3/14/17. Employee #14, a certified nursing assistant, was hired 6/28/16. The criminal background check obtained was dated 3/14/17 and not done within 30 days of the hire date.

The surveyor also reviewed employee #20's record. Employee #20 was a registered nurse and was hired 7/14/16. The surveyor noted that employee #20's licensed expired on 10/31/16. No current licensure was observed in employee #20's record.

The surveyor and other #4 also identified that 2 reference checks were not obtained for employee #1, employee #2, employee #5, employee #9 and only one reference check was obtained for employee #12 and employee #20.

Upon completion of the employee record review, other #4 stated the criminal background checks for employee #7 and employee #14 had been

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| F 226 | Continued From page 7<br>done on hire and the facility was charged for the background checks but stated the results were never sent. Other #4 also reviewed the current notebook for license verification; however, employee #20's RN license verification was not in the notebook. Other #4 also offered no reason as to why the employee reference checks were not done.<br><br>The surveyor informed the administrative staff of the above issues with criminal background checks not done, license verification not completed, and reference checks not obtained prior to hire in a meeting on 3/16/17 at 10:30 a.m.<br><br>No further information was provided prior to the exit conference on 3/16/17. | F 226 | | |
| F 272 SS=E | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>(b) Comprehensive Assessments<br><br>(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br><br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems. | F 272 | F-272 Comprehensive Assessments<br><br>It is the practice of this facility to complete a comprehensive assessment of a resident's needs, strengths, goals, life history, and preferences utilizing the Resident Assessment Instrument.<br><br>1. The Care Area Assessment Summary for ,Residents # 1,2,3.4,5,6,7,8,9,11 and 12 were corrected to include the documentation of the location where the CAA Information could be found in section V. This was completed by the MDS staff on 3/24/17.<br>2. Other residents from survey sample of residents Care Area Assessment summaries were also updated to include the documentation of the location where the CAA information could be found in section V. This was completed by MDS staff on 3/24/17. | |

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| F 272 | Continued From page 8<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.<br><br>The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to ensure complete and accurate Care Area Assessments (CAA's) for 11 of 22 Residents. Residents #5, #7, #8, #3, #9, #11, #1, #6, #12, #2 and #4.<br><br>The findings included.<br><br>1. For Resident #5, the facility staff failed to identify the location where the CAA information | F 272 | 3. The Regional Reimbursement Director in-serviced the MDS staff on completion of the Care Area Assessment Summary to include CAA information could be found on 3/15/17.<br>4. The MDS staff will audit the Care Area Assessment Summary for Comprehensive Assessments x 3 months to validate the documentation of the location where the CAA information can be found. Audits will be reviewed by Quality Assurance Performance Improvement committee x 3 months for ongoing monitoring and recommendations. | |

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could be found in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/11/16.

The record review revealed that Resident #5 had been admitted to the facility 04/05/14. Diagnoses included, but were not limited to, acute/chronic respiratory failure, anemia, hypertension, chronic obstructive pulmonary disease, and hypothyroidism.

Section C (cognitive patterns) of the Residents annual MDS assessment included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

The directions under section V of this assessment read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

For the area of psychosocial well-being the column labeled "Location and Date of CAA documentation" only included the following documentation "CAA WS (worksheet) dated 7/21/2016." For the area of nutritional status the facility staff had documented "CAA WS dated 7/15/2016" and for the area of dental care the facility staff had documented "CAA WS dated 7/18/2016." The actual location(s) regarding the documentation had not been identified.

On 03/15/17 at approximately 10:40 a.m. the surveyor and LPN (licensed practical nurse) #1 reviewed the MDS and the CAA information and was unable to locate any documentation to indicate where this information could be found.

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The administrative team was made aware of the missing CAA information during a meeting with the survey team on 03/15/17 at 3:15 p.m. During this meeting the administrative team verbalized to the surveyors that the staff had been inserviced on completing the CAA information.

No further information regarding the missing MDS information was provided to the survey team prior to the exit conference.

2. For Resident #7, the facility staff failed to identify the location where the CAA information could be found in section V (care area assessment (CAA) summary) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/31/16.

The record review revealed that Resident #7 had been admitted to the facility 09/10/14. Diagnoses included, but were not limited to, anorexia, age related osteoporosis, dementia, dysphagia, and hypothyroidism.

Section C (cognitive patterns) of the Residents significant change in status MDS assessment was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making.

The directions under section V of this assessment read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

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For the area of nutrition the column labeled "Location and Date of CAA documentation" only included the following documentation "CAA WS (worksheet) dated 4/7/2016." The actual location(s) regarding the documentation had not been identified.

On 03/14/17 at approximately 4:15 p.m. the surveyor and the dietician reviewed the MDS and the CAA information and were unable to locate any documentation to indicate where this information could be found. The dietician verbalized to the survey team that she wasn't aware that piece needed to be completed.

The administrative team was made aware of the missing CAA information during a meeting with the survey team on 03/15/17 at 3:15 p.m. During this meeting the administrative team verbalized to the surveyors that the staff had been inserviced on completing the CAA information.

No further information regarding the missing MDS information was provided to the survey team prior to the exit conference.

3. For Resident #8, the facility staff failed to identify the location where the CAA information could be found in section V (care area assessment (CAA) summary) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/17/16.

The record review revealed that Resident #8 had been admitted to the facility 09/30/16. Diagnoses included, but were not limited to, Parkinson's disease, chronic obstructive pulmonary disease, anemia, diabetes, and peripheral vascular

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disease.

Section C (cognitive patterns) of the Residents admission MDS assessment included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

The directions under section V of this assessment read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

For the area of nutrition the column labeled "Location and Date of CAA documentation" only included the following documentation "CAA WS (worksheet) dated 10/12/16." The actual location(s) regarding the documentation had not been identified.

On 03/14/17 at approximately 4:15 p.m. the dietician verbalized to the survey team that she wasn't aware that piece needed to be completed.

The administrative team was made aware of the missing CAA information during a meeting with the survey team on 03/15/17 at 3:15 p.m. During this meeting the administrative team verbalized to the surveyors that the staff had been inserviced on completing the CAA information.

No further information regarding the missing MDS information was provided to the survey team prior to the exit conference.
4. The facility staff failed to complete the Care Area Assessment (CAA) Summary section of the significant change Minimum Data set (MDS) for Resident #3.

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Resident #3 was admitted to the facility on 2/18/15 with diagnoses of congenital pneumonia, schizophrenia, anxiety, depression, dysphagia, chronic respiratory failure, congestive heart failure, psychosis, chronic obstructive pulmonary disease, hypertension, and anemia.

The significant change Minimum Data Set (MDS) with a reference date of 1/16/17 assessed the resident with a cognitive score of "13" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, hygiene and bathing.

Section "V" for Care Area Assessment was reviewed. The facility staff failed to include the location and date for the CAA areas for "feeding tube" and "nutrition". The areas just stated, "See CAA WS (work sheet) dated 1/11/17". The CAA WS was reviewed for these areas and there was no documentation of where and/or the date this information could be located.

The registered dietitian (RD) was asked by the survey team on 3/14/17 at approximately 4:25 p.m. about the date and location of the information she provided for the CAA summary. The RD stated she had not been instructed to provide the information and had failed to do so.

The administrator, director of nursing, and corporate nurses were informed of the findings during an end of the day meeting with the survey team on 3/14/17.

5. The facility staff failed to complete the Care Area Assessment (CAA) Summary section of the annual Minimum Data set (MDS) for Resident #9.

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Resident #9 was admitted to the facility on 8/21/15 with diagnoses of chronic kidney disease, anxiety, stroke, chronic pain syndrome, urinary retention, bipolar disease, hypertension, coronary artery disease, myocardial infarction, and anemia.

The annual Minimum Data Set (MDS) with a reference date of 5/11/16 assessed the resident with a cognitive score of "15" of "15". The resident was assessed requiring total to extensive assistance of 1-2 persons for bed mobility, transfers, dressing, toileting, hygiene and bathing.

Section "V" for Care Area Assessment was reviewed. The facility staff failed to include the location and date for the CAA areas for "falls" and "nutrition". The areas just stated, "See CAA WS (work sheet) dated 5 /11/16" for falls and 5/16/16 for nutrition. The CAA WS was reviewed for these areas and there was no documentation of where and/or the date this information could be located.

The registered dietitian (RD) was asked by the survey team on 3/14/17 at approximately 4:25 p.m. about the date and location of the information she provided for the CAA summary. The RD stated she had not been instructed to provide the information and had failed to do so.

The MDS co-ordinator was interviewed on 3/15/17 at 10:20 a.m. regarding the omission of documentation on the CAA summary. She stated she missed it.

The administrator, director of nursing, and corporate nurses were informed of the findings during an end of the day meeting with the survey

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team on 3/14/17.

6. The facility staff failed to complete the Care Area Assessment (CAA) Summary section of the annual Minimum Data set (MDS) for Resident #11.

Resident #11 was admitted to the facility on 4/16/14 with diagnoses of respiratory failure, hypertension, spina bifida, asthma, mild intellectual disability, seizure disorder, depression, sleep apnea, epilepsy, dysphagia, and gastro-esophagel reflux disease.

The annual Minimum Data Set (MDS) with a reference date of 4/10/16 assessed the resident with a cognitive score of "8" of "15". The resident was assessed requiring supervision to extensive assistance of 1-2 persons for bed mobility, transfers, ambulation, dressing, toileting, hygiene and bathing.

Section "V" for Care Area Assessment was reviewed. The facility staff failed to include the location and date for the CAA areas for "cognitive loss/dementia" and "nutrition". The areas just stated, "See CAA WS (work sheet) dated 4 /18/16" for cognitive loss/dementia and 4/12/16 for nutritional status. The CAA WS was reviewed for these areas and there was no documentation of where and/or the date this information could be located.

The registered dietitian (RD) was asked by the survey team on 3/14/17 at approximately 4:25 p.m. about the date and location of the information she provided for the CAA summary. The RD stated she had not been instructed to provide the information and had failed to do so.

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The MDS co-ordinator was interviewed on 3/15/17 at 10:20 a.m. regarding the omission of documentation on the CAA summary. She stated she missed it.

The administrator, director of nursing, and corporate nurses were informed of the findings during an end of the day meeting with the survey team on 3/14/17.
7. The facility staff failed to document location and date of the information used to complete Section V of the CAA (Care Area Assessment) on the admission MDS (minimum data set) assessment for Resident #1. The Care Area Assessment (CAA) worksheets did not include the date and location of documentation to support the triggered areas of visual function, falls, nutritional status, and dental care.

The clinical record of Resident #1 was reviewed 3/14/17 and 3/15/17. Resident #1 was admitted to the facility 7/19/16 and readmitted 2/27/17 with diagnoses that included but not limited to dementia with behavioral disturbances, major depressive disorder, hypokalemia, mild cognitive impairment, dysphagia, anuria and oliguria, homicidal ideations, suicidal ideations, weakness, encephalopathy, chronic kidney disease, pseudobulbar effect, hypothyroidism, iron deficiency anemia, type 1 diabetes mellitus, obesity, and hypertension.

Resident #1's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/29/16 assessed the resident with a cognitive summary score of 14 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors directed toward others.

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Section V CAA was reviewed. Resident #1 was noted to have the following triggered areas that were targeted to be care planned: visual function, ADL (activities of daily living), urinary, falls, nutritional status, dental care, pressure ulcer, and psychotropic drug use. The location and date of CAA documentation was not found for the triggered areas of visual function, falls, nutritional status, and dental care. The only information documented for visual function, falls, nutritional status, and dental care was "CAA (care area assessment) WS (worksheet) dated 8/1/16."

The surveyor interviewed licensed practical nurse #1 on 3/14/17 at 4:00 p.m. concerning the absence of the location and date of documentation to support the triggered areas for visual function, falls, nutritional status and dental care. L.P.N. #1 stated "I see your point."

The directions under section V of this assessment read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 3/15/17 at 3:15 p.m.

No further information was provided prior to the exit conference on 3/16/17.

8. The facility staff failed to document location and date of the information used to complete Section V of the CAA (Care Area Assessment) on the annual MDS (minimum data set) assessment with an assessment reference date (ARD) of

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10/21/16 for Resident #6. The Care Area Assessment (CAA) worksheets did not include the date and location of documentation to support the triggered areas of nutritional status and feeding tube.

The clinical record of Resident #6 was reviewed 3/14/17 through 3/16/17. Resident #6 was admitted to the facility 1/13/13 and readmitted 7/19/15 with diagnoses that included but not limited to osteomyelitis, sepsis, hypokalemia, hypocalcemia, cerebrovascular accident (CVA), traumatic brain injury, bacteremia, respiratory failure with dependence on ventilator, chronic obstructive pulmonary disease, anxiety, dysphagia, type 1 diabetes mellitus, hypertension, anemia, hyperlipidemia, urine retention, and hemiplegia.

Resident #6's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/21/16 assessed to interview staff for mental status. Staff assessment for mental status identified Resident #6 with short term memory problems, long term memory problems and severely impaired cognitive skills for daily decision making.

Section V CAA was reviewed. Resident #6 was noted to have the following triggered areas that were targeted to be care planned: cognitive loss/dementia, visual function, communication, urinary, activities, falls, nutritional status, feeding tube, dehydration/fluid maintenance, pressure ulcer, psychotropic drug use and pain. The location and date of CAA documentation was not found for the triggered areas of nutritional status and feeding tube. The only information documented for nutritional status and feeding

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tube care was "CAA (care area assessment) WS (worksheet) dated 10/26/16."

The surveyor interviewed registered dietician other #1 on 3/14/17 at 4:15 p.m. RD other #1 stated she was unaware that she needed to be specific on the location in Section V. RD other #1 stated a nutrition assessment was always done within that period.

The surveyor informed the administrative staff of the inaccuracy of Resident #6's Section V CAA of the annual MDS in the end of the day meeting on 3/15/17 at 3:15 p.m.

No further information was provided prior to the exit conference on 3/16/17.

9. The facility staff failed to document location and date of the information used to complete Section V of the CAA (Care Area Assessment) on the annual MDS (minimum data set) assessment with an assessment reference date (ARD) of 1/25/17 for Resident #12. The Care Area Assessment (CAA) worksheets did not include the date and location of documentation to support the triggered areas of nutritional status.

The clinical record of Resident #12 was reviewed 3/14/17 and 3/15/17. Resident #12 was admitted to the facility 7/16/12 and readmitted 1/11/17 with diagnoses that included but not limited to emphysema, chronic airway obstruction, tobacco use, atherosclerosis of the coronary artery, acute MI (myocardial infarction), hypercapneic respiratory failure, pulmonary heart disease, and alcohol dependence.

Resident #12's annual minimum data set (MDS)

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assessment with an assessment reference date of 1/25/17 assessed the resident with a cognitive summary score of 15 out of 15.

A review of the annual MDS referenced above revealed Resident #12 triggered for the following areas in Section V: ADL Functional/Rehabilitation, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dental Care, Pressure Ulcer, Psychotropic Drug Use, and Pain. The column titled "Location and Date of CAA Documentation" was reviewed. The documentation for nutritional status read "CAA WS (worksheet) dated 1/25/17."

The directions under section V of this assessment read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

The surveyor interviewed registered dietician other #1 on 3/14/17 at 4:15 p.m. RD other #1 stated she was unaware that she needed to be specific on the location in Section V. RD other #1 stated a nutrition assessment was always done within that period.

The surveyor informed the administrative staff of the inaccuracy of Resident #12's Section V CAA of the annual MDS in the end of the day meeting on 3/15/17 at 3:15 p.m.

No further information was provided prior to the exit conference on 3/16/17.

10. The facility staff failed to document the dates and/or locations for where the documentation could be found in Resident#2's clinical record for Section V of the Care Area

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assessment (CAA) Summary of the Minimum Data Set (MDS).

Resident #2 was readmitted to the facility on 11/19/16 with the following diagnoses of, but not limited to anemia, high blood pressure, neurogenic bladder, diabetes, cerebral palsy, paraplegia, seizure disorder, anxiety disorder, depression, and stage IV pressure ulcer. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/3/17 with a BIMS (Brief Interview for Mental Status, an assessment tool used) with a score of 15 out of a possible score of 15. Resident #2 was also coded as being totally dependent on 2 members for dressing and bathing.

The surveyor conducted a clinical record review of Resident #2's chart on 3/14/17. The surveyor noted that on the MDS with an ARD of 5/12/16 in Section V of the CAA Summary the dates and locations of the documentation to support the triggered area were not properly documented for Nutritional Status. Under the "Nature of the problem/condition" for Nutritional Status the following was noted to be documented: "Resident is obese with BMI (Body Mass Index) 39.1. Therapeutic diet r/t (related to) hx (history) DM (Diabetes Mellitus). Resident with persistent pressure ulcer to sacrum stage 4."

Other staff member #1 was interviewed on 3/14/17 at 4:15 pm in the conference room by the surveyor. The surveyor asked the other staff member #1 where the dates and location of the documentation for nutritional status on the CAA Summary, Section V. The other staff member #1 stated, "I didn't know that I had to put this information on the CAA Summary and I didn't

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even know I had a place to document that."

The administrative team was notified of the above documented findings in the end of the day conference on 3/15/17 at approximately 3:15 pm by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 3/16/17.

11. The facility staff failed to document the dates and/or locations for where the documentation could be found in Resident #4's clinical record for Section V of the Care Area assessment (CAA) Summary of the Minimum Data Set (MDS).

Resident #4 was admitted to the facility on 11/28/16 with the following diagnoses of, but not limited to Urinary Tract Infection, renal insufficiency, obstructive uropathy, pneumonia, viral hepatitis, hemiplegia, respiratory failure, and chronic pain. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/5/16, the resident was coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) score of 15 out of a possible score of 15. Resident #4 was also coded as being totally dependent on 2 staff members for dressing, personal hygiene and bathing.

The surveyor conducted a clinical record review of Resident #4's chart on 3/15/17. The surveyor noted that on the MDS with an ARD of 12/5/16 in Section V of the CAA Summary the locations of the dates and/or documentation to support the following triggered area were not properly documented for: Feeding Tube and Nutritional

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| F 272 | Continued From page 23<br>Status. Under the "Nature of the problem/condition" for Nutritional Status the following was noted to be documented: "Resident is overweight with BMI (Body Mass Index) 29.1." The following was also noted under the "Nature of the problem/condition" for Feeding Tube which stated "Feeding Tube in use r/t dysphagia."<br><br>Other staff member #1 was interviewed on 3/14/17 at 4:15 pm in the conference room by the surveyor. The surveyor asked the other staff member #1 where the dates and location of the documentation for nutritional status on the CAA Summary, Section V. The other staff member #1 stated, "I didn't know that I had to put this information on the CAA Summary and I didn't even know I had a place to document that."<br><br>The administrative team was notified of the above documented findings in the end of the day conference on 3/15/17 at 3:15 pm by the surveyor.<br><br>No further information was provided to the surveyor prior to the exit conference on 3/16/17. | F 272 | | |
| F 309 SS=E | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. | F 309 | F-309 Provide Care and Services for Highest Well Being<br><br>1. A pain assessment was completed by Licensed Nurse for residents # 2 and # 6 on 3/29/17. Non- pharma logical Interventions specific to each patient was added to their care plans on 3/29/17. | |

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483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for 2 of 22 residents (Resident #6 and Resident #2).

The findings included:

1. The facility staff failed to complete pain

2. Pain scores are obtained each shift for each resident and documented on The Medication Administration Record by the Licensed Nurse. Non-Pharmacological Interventions for pain have been added to Resident Care Plans by 4/3/17.
3. Licensed Nurses were in-serviced By the Director of Nursing/Designee on providing documentation of the non-pharmacological intervention that was utilized prior to the administration of PRN pain medication on 3/27/17.
4. The Director of Nursing/Designee will complete an audit weekly of Medication Administration Record for PRN pain medications to validate documentation of Non-Pharmacological Interventions. Audits will be reviewed by Quality Assurance Performance Improvement Committee monthly X 3 months.

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assessments and failed to offer non-pharmacological interventions for pain prior to pain medication administration for Resident #6.

The clinical record of Resident #6 was reviewed 3/14/17 through 3/16/17. Resident #6 was admitted to the facility 1/13/13 and readmitted 7/19/15 with diagnoses that included but not limited to osteomyelitis, sepsis, hypokalemia, hypocalcemia, cerebrovascular accident (CVA), traumatic brain injury, bacteremia, respiratory failure with dependence on ventilator, chronic obstructive pulmonary disease, anxiety, dysphagia, type 1 diabetes mellitus, hypertension, anemia, hyperlipidemia, urine retention, hemiplegia.

Resident #6's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/21/16 assessed to interview staff for mental status. Staff assessment for mental status identified Resident #6 with short term memory problems, long term memory problems and severely impaired cognitive skills for daily decision making. Resident #6 was assessed without delirium, psychosis, or behaviors that were directed at others. Section G Functional Status assessed the resident to be totally dependent of 2 people for bed mobility, dressing, toileting and personal hygiene. Section J Health Conditions and specifically Section J0100 Pain Management assessed that resident had received prn (as needed) medication or was offered and declined. J0200 Pain Assessment Interview read that an interview should not be done and skip to J0800 Indicators of Pain or Possible Pain. J0800 Staff Assessment of Resident Pain in the last 5 days was marked that Resident #6 used protective body movements or

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postures as indicators of pain and that these were observed 3-4 days.

Resident #6's current comprehensive care plan revised 11/3/16 identified pain as a focus area and read under interventions to administer analgesia per orders and to evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.

The February 2017 physician order sheet included an order that read "Hydrocodone-Acetaminophen 5 mg (milligrams)-325 mg tablet for > Hydrocodone-Acetaminophen 1 tab (tablet) via tube every 6 hours as needed for pain."

The February 2017 medication administration records (MARs) were reviewed. Resident #6 received prn (as needed) pain medications every day in February except 2/1/17, 2/8/17, and 2/28/17. On 2/5/17, 2/9/17, 2/10/17, 2/11/17, 2/14/17, 2/16/17, 2/17/17, 2/18/17, 2/20/17, 2/21/17, 2/22/17, 2/26/17, and 2/27/17 Resident #6 received prn Hydrocodone-Acetaminophen 5-325 mg.

The February 2017 progress notes did not reveal evidence that a pain assessment had been done or that any non-pharmacological interventions had been done prior to medication administration on any of the dates in February 2017.

The February 2017 progress notes were requested from administrative staff #4 but never received by the surveyor from the facility staff.

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Administrative staff #4 stated there was no documentation that non-pharmacological interventions were used prior to medication administration.

The reverse side of the February 2017 medication administration record documented Resident #6 received hydrocodone-acetaminophen 5-325 mg on 2/2/17, 2/3/17, 26/17, 2/7/17, 2/14/17, 2/15/17, 2/16/17, 2/17/17, 2/19/17, 2/20/17, 2/21/17, 2/22/17, 2/24/17, 2/26/17, and 2/27/17. The documentation stated the medications were given for "Gen Pain."

The February 2017 medication administration record documented that staff were to monitor the resident for pain every shift; however, the medication administration record did not identify what type of pain scale (0-10) or non-verbal indicators of pain would be assessed. The pain monitor documented on the February 2017 MAR documented a numerical value. The annual MDS with an ARD of 10/21/16 J0200 Staff Assessment of Resident Pain in the last 5 days was marked that Resident #6 used protective body movements or postures as indicators of pain and that these were observed 3-4 days.

The failure of the facility to assess Resident #6 for pain and to not offer/use non pharmacological interventions prior to medication administration was discussed in the end of the day meeting on 3/16/17 at 10:30 a.m. with the administrative staff.

The surveyor requested the policy on pain from the administrative staff other #4 on 3/16/17 at 10:30 a.m.

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No further information was provided prior to the exit conference on 3/16/17.

2. The facility staff failed to document non-pharmacological interventions prior to the administration of pain medications to Resident #2.

Resident #2 was readmitted to the facility on 11/19/16 with the following diagnoses of, but not limited to anemia, high blood pressure, neurogenic bladder, diabetes, cerebral palsy, paraplegia, seizure disorder, anxiety disorder, depression, and stage IV pressure ulcer. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/3/17 with a BIMS (Brief Interview for Mental Status, an assessment tool used) with a score of 15 out of a possible score of 15. Resident #2 was also coded as being totally dependent on 2 members for dressing and bathing.

The surveyor performed a clinical record review of Resident #2's medical record on 3/15/17. The medication "Cyclobenzaprine (Flexaril) 5 mg (milligram) 1 tab (tablet) by mouth every 8 hours as needed (muscle spasm/neck pain) was ordered by the physician to be given to Resident #2. Resident #2 received this medication on the following dates and times: "2/2/17 at 3a (am), 2/15/17 at 1a, 2/16/17 at 11:30 pm, 2/24/17 at 1800 (6 pm), 3/1/17 at 11:50, 3/9/17 at 1 am, 3/10/17 at 12 am and 9 am and 3/12/17 at 1:20."

The nurses' notes were reviewed by the surveyor for the above documented dates of times that the medication, Flexaril, was given to the resident. There were no non-pharmacological interventions documented prior to the administration of this medication to Resident #2.

Resident #2's comprehensive care plan was also reviewed by the surveyor. Under the focus of

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| F 309 | Continued From page 29<br>Pain the following interventions were documented:<br>"Administer analgesia as per orders.<br>Anticipate my need for pain relief and respond immediately to any complaint of pain.<br>Evaluate the effectiveness of pain interventions.<br>Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.<br>Monitor/record pain characteristics PRN (as needed) ...<br>Notify physician if interventions are unsuccessful or if current complaint is a significant change from the residents past experience with pain."<br>The administrative team was notified of the above documented findings by the surveyor on 3/15/17 at approximately3:15 pm.<br><br>No further information was provided to the surveyor prior to the exit conference on 3/16/17. | F 309 | | |
| F 328 SS=D | 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:<br><br>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and<br><br>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments | F 328 | F328 Treatment/care for special needs<br>1. The MD was notified that the medication Amikacin for resident # 10 was administered Q 48 hours instead of Q 36 Hours per order. A medication error report was completed.<br>2. An audit of other the orders of other residents receiving antibiotics was completed by the Director of Nursing/Designee to validate accurate scheduling of the medication. This audit was completed on 3/23/17.<br>3. The licensed nurses were in-serviced on accurate scheduling of times of antibiotics on the Medication Administration Record per MD order by the Director of Nursing/Designee on 3/29/17. | |

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| F 328 | Continued From page 30<br>(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.<br><br>(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br><br>(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.<br><br>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br><br>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the | F 328 | 4. The Director of Nursing/Designee will audit Medication Administration Record of new antibiotic orders to validate accurate scheduling of times for the administration of the antibiotic. Audits will be reviewed by Quality Assurance Performance Improvement Committee monthly x 3 months. | |

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prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility failed to administer a physician ordered intravenous antibiotic as prescribed for 1 of 22 residents in the survey sample (Resident #10).

The findings included:

Resident #10 was readmitted to the facility on 2/25/15 with the following diagnoses of, but not limited to anemia, high blood pressure, paraplegia, malnutrition, anxiety disorder, chronic obstructive pulmonary disease and respiratory failure. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/16/16 as having a BIMS (Brief Interview for Mental Status, an assessment protocol) score of 15 out of a possible score of 15. Resident #10 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing.

The clinical record of Resident #10 was reviewed by the surveyor on 3/15/16. It was noted by the surveyor during this review the following physician order dated for 2/25/17 which stated: "Amikacin 700 mg (milligram) IV (intravenous) every 36 hours." The surveyor reviewed the MAR (Medication Administrative Record) of Resident #10 for the administration of the above documented antibiotic for February, 2017. The surveyor noted the following documentation on the resident's MAR for February, 2017: "Amikacin 700 mg IV every 36 hours" ...under the hour it is written in "5 am".

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| F 328 | Continued From page 32<br>In the box under the date for 2/26/17, their initials in the box representing that this medication had been given at 5 am.<br>The next box marked with initials representing that this medication had been given was 2/28/17 at 5 am.<br><br>The administrative staff member #3 was notified of the above documentation findings by the surveyor on 3/15/17 at 2 pm. The administrative staff member #3 stated to the surveyor "It was given in 48 hours instead of 36 hours."<br><br>The administrative staff was notified of the above documented findings on 3/15/17 at 3:15 pm in the conference room by the surveyor.<br><br>No further findings were provided to the surveyor prior to the exit conference on 3/16/17. | F 328 | | |
| F 329 SS=D | 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or | F 329 | F-329 Drug Regimen is free from Unnecessary Drugs<br><br>1. A Behavior flow sheet has been initiated for Resident #6 to include documentation of non-pharmacological interventions to be utilized prior to administration of PRN Ativan.<br>2. Other Residents receiving Antipsychotic medications will have Behavior Flow sheets initiated on 4/1/17 to document episodes of identified behavior and non-pharmacological interventions.<br>3. Licensed Nursing staff have been in-serviced on the use and documentation of the Behavior flow sheet to include non-pharmacological interventions for patients receiving antipsychotic medications. In-service completed on 3/27/17. | |

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| F 329 | Continued From page 33<br>discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>483.45(e) Psychotropic Drugs.<br>Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and facility document review, the facility staff failed to ensure 1 of 22 residents (Resident #6) was free from an unnecessary medication.<br><br>The findings included:<br><br>The facility staff failed to use non -pharmacological interventions before the use of the antianxiety medication Ativan for Resident #6. Resident #6 was administered PRN (as needed) Lorazepam (Ativan) without any indication of the attempt to use non-pharmacological interventions prior to the administration. The facility staff failed to identify the targeted behavior for the use of the prn Ativan and failed to provide evidence of | F 329 | 4. The Director of Nursing/Designee will audit Behavior flow sheets weekly x 3 months to validate documentation of non-pharmacological interventions prior to administration of PRN antipsychotics. Results of audits will be reviewed by QAPI Committee monthly x 3 months for ongoing monitoring and recommendations. | |

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monitoring when the anxiolytic was administered.

The clinical record of Resident #6 was reviewed 3/14/17 through 3/16/17. Resident #6 was admitted to the facility 1/13/13 and readmitted 7/19/15 with diagnoses that included but not limited to osteomyelitis, sepsis, hypokalemia, hypocalcemia, cerebrovascular accident (CVA), traumatic brain injury, bacteremia, respiratory failure with dependence on ventilator, chronic obstructive pulmonary disease, anxiety, dysphagia, type 1 diabetes mellitus, hypertension, anemia, hyperlipidemia, urine retention, hemiplegia.

Resident #6's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/21/16 assessed to interview staff for mental status. Staff assessment for mental status identified Resident #6 with short term memory problems, long term memory problems and severely impaired cognitive skills for daily decision making.

The current comprehensive care plan revised 2/21/17 identified the focus area that read "I am at risk for side effects from antianxiety medication. Anxiety disorder PRN (whenever necessary) anxiety medication. Interventions: Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness."

The February 2017 physician order sheet read in part "Lorazepam 0.5 mg (milligram) tablet for > Ativan Take 1 tab via peg (feeding) tube twice daily as needed for agitation."

The February 2017 medication administration

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| RIDGECREST MANOR NURSING & REHABILITATION | 157 ROSS CARTER BOULEVARD DUFFIELD, VA 24244 |

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| F 329 | Continued From page 35<br>record (MAR) was reviewed. Resident #6 was administered Ativan 0.5 mg eleven times. The reverse side of the February 2017 medication administration record documented Ativan was administered due to increased agitation. No specific behavior was documented on the February 2017 MAR. The February progress notes were reviewed and failed to indicate any documentation that non-pharmacological interventions were used prior to the use of the medication Ativan.<br><br>The facility staff failed to identify the targeted behavior for Resident #6's Ativan use, failed to monitor the behavior and failed to incorporate non-pharmacological interventions prior to the administration of Ativan.<br><br>The surveyor informed the administrative staff of the above finding on 3/15/17 at 3:15 p.m. and requested the February 2017 progress notes and the February 2017 behavior monitoring sheets.<br><br>No further information was provided prior to the exit conference on 3/16/17. | F 329 | | |
| F 333 SS=E | 483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>483.45(f) Medication Errors.<br><br>The facility must ensure that its-<br><br>(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to ensure 2 of 22 | F 333 | F-333 Residents Free of Medication Errors<br><br>1. The Sliding Scale Insulin orders for Residents # 8 and #9 were revised by the Nurse Practitioner to provide coverage from 0-451 BS results as well as high and low parameters for notification of the MD. This was completed on 3/15/17.<br>2. Other resident's with sliding scale insulins orders were reviewed by the Medical staff and revised to include SSI coverage from 0-451 as well as high and low parameters for notification of the physician. | |

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residents (Resident #9 and #8) were free from significant medication errors in the area of diabetic management.

The findings include:

1. The facility staff failed to follow the physician orders for administration of insulin via sliding scale for Resident #9.

Resident #9 was admitted to the facility on 8/21/15 with diagnoses of chronic kidney disease, anxiety, stroke, chronic pain syndrome, urinary retention, bipolar disease, hypertension, coronary artery disease, myocardial infarction, and anemia.

The annual Minimum Data Set (MDS) with a reference date of 5/11/16 assessed the resident with a cognitive score of "15" of "15". The resident was assessed requiring total to extensive assistance of 1-2 persons for bed mobility, transfers, dressing, toileting, hygiene and bathing.

The clinical record was reviewed. The physician had ordered Novolog Insulin via sliding scale four times daily as follows:
For blood sugars 151-200 give 2 units subcutaneous
For blood sugar 201- 250= 3 units
For blood sugar 251- 300= 5 units
For blood sugar 301-350= 7 units
for blood sugar >(greater than) 350=9 units and notify physician.

The physician additionally ordered on 2/21/17 , "If blood glucose BG (sugar) > 350 give additional 6 units with 9 units and with 9 units recheck in 1 hour if > 450 notify MD".

3. Nursing staff were in-serviced by the Director of Nursing/Designee on 3/27/17 regarding Sliding scale insulin management, documentation and notification of MD per established high and low parameters.
4. The Director of Nursing/Designee will audit Medication Administration Record and Nurses Progress notes weekly x 3 months to validate SSI administered per order and MD notified per established parameters. The Director of Nursing will review audits monthly during Quality Assurance Performance Improvement Committee Monthly x 3 months for on-going monitoring and recommendations.

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The February 2017 medication administration record (MAR) was reviewed. Resident #9 was given 9 units of Novolog insulin multiple times in February. The nurses administered 9 units at 6:00 a.m. on 2/4 for BG of 512, 2/5 for BG 348, 2/6/ for BG 350, 2/16 for BG 348, 2/22 for BG illegible, and 2/27 for BG 459. The only documentation the nurse notified the physician was dated 2/22. It was not determined if the recheck BG level was obtained after 2/22 or if additional 6 units of insulin were administered. The nurse also administered the 9 units when the BG level was below 350.

The nurses administered 9 units at 11:00 am. on 2/3 for BG of 407. Again no notification was documented the physician was notified.

The nurse administered 9 units at 4:00 p.m. on 2/3 for BG of 487, 2/16 for BG of 507, 2/21 for BG of 430, 2/22 for Bg 367, 2/23 for BG of 404, and 2/27 for BG of 364. The nurses failed to notify the physician for BG > 350 and failed to obtain a recheck BG level as ordered.

The nurses administered 9 units at 9:00 p.m. on 2/2 for BG of 350, 2/3 for BG 355, 2/4 for BG of 348, 2/5 for BG of illegible amount, 2/10 for BG of 348, 2/16 for BG of 462, 2/21 for BG of 469, and 2/26 for Bg of 453. The nurses failed to notify the physician of BG > 350 , recheck the BG if BG > 450, and administered the additional 6 units for BG > 350.

The March 2017 MAR was reviewed. The MAR contained the same sliding scale orders for insulin except the nurses had written to give an additional 16 units instead of 6 units for BG > 350.

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The nurses administered 9 units at 6:00 a.m. on 3/4 for BG of 503, 3/5 for BG of 431, 3/10 for BG of 364, and 3/11 for BG of 428. The nurse documented on the back of the MAR on 3/11 at 7:00 a.m. the BG was rechecked at 440 after 16 units additional units.

The nurses administered 9 units of insulin at 11:00 a.m. on 3/4 for BG of 356, 3/8 for BG of 389, and 3/9 for BG of 421.

The nurses administered 9 units at 4:00 p.m. on 3/8 for BG of 367, and 3/9 for BG of 456.

The nurses administered 9 units of insulin at 9:00 p.m. on 3/1 for BG of 414, 3/2 for BG of 492, 3/3/ for BG of 350, 3/4 for BG of 367, 3/7 for BG of 500, 3/9 for BG of 454, 3/10 for BG of 402, and 3/11 for BG of 365. The nurse documented on the back of the MAR for 3/10 at 2200 (10:00 pm.) the BG was rechecked after 16 additional units given and in 1 hr BG was 377.

The nurses documented on the back of the MAR on 3/14 at 11:00 a.m. the resident refused insulin coverage x 3
The nurses documented on the back of the MAR on 3/14 at 4:00 p.m. the resident refused insulin coverage x 3 attempts.

There were two additional recordings of BG levels below the four times ordered on the MAR without documentation of times. The nurses documented administration of 16 units of insulin on 3/7 for BG of 500, 3/9 for BG of 454 and on 3/10 for BG of 364. There was no documentation the physician was notified of BG levels >350.

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The discrepancies in insulin administration were discussed with the director of nursing on 3/15/17 at 11:20 a.m. The corporate nurses were also informed and a plan of correction was discussed with the physician's nurse practitioner.

The administrator, director of nursing, and corporate nurses were informed of the findings during an end of the day meeting with the survey team on 3/15/17.

2. For Resident #8, the facility staff failed to follow the physician ordered parameters for sliding scale insulin and failed to obtain BS (blood sugar) parameters for blood sugar readings greater than 340.

The record review revealed that Resident #8 had been admitted to the facility 09/30/16. Diagnoses included, but were not limited to, Parkinson's disease, chronic obstructive pulmonary disease, anemia, diabetes, and peripheral vascular disease.

Section C (cognitive patterns) of the Residents admission MDS assessment included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section I (active diagnoses) included the diagnosis of diabetes.

The Residents CCP (comprehensive care plan) included the focus area "I am a diabetic. I require insulin to control my diabetes." Interventions included, but were not limited to, administer insulin and /or oral medication as ordered and obtain blood sugars as ordered. Report any BS outside of treatment parameters to MD.

The most current POS (physician order sheet) included an order for humalog insulin inject four

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times daily per sliding scale. This order read for a BS of 141-180 give 3 units, 181-220 give 6 units, for 221-260 give 8 units, for 261-300 give 10 units, and for 301-340 give 15 units. There were no parameters for a blood sugar greater than 340.

Resident #8 also received 40 units of lantus insulin at bedtime.

A review of the Residents MARs (medication administration records) for February and March 2017 revealed that when the Residents BS's were greater than 340 the nursing staff documented they administered 15 units of insulin. Except for 03/07 at 4:00 p.m. and on 03/08 at 11:00 a.m. when LPN #2 had documented they had administered 10 units.

February BS greater than 340-
11:00 a.m. on 02/22-375, 02/23-402, and 02/25-348.
4:00 p.m. on 02/14-465, 02/19-372, 02/26-510, and 02/28-394.
9:00 p.m. on 02/20-391 and on 02/26-52_ (unable to read).

March BS greater than 340-
11:00 a.m. 03/01-344 and 03/08-590.
4:00 p.m. 03/01-418, 03/07-511, 03/08-393 and on 03/09-380.
9:00 p.m. 03/07-415

Also on 02/22/17 at 6:00 a.m. the facility nursing staff documented they administered 3 units of insulin for a BS of 191 when the Resident should have received 6 units.

On 03/15/17 at approximately 10:00 a.m. the

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surveyor reviewed the MAR's with LPN (licensed practical nurse) #2 after identifying her initials on the MAR for 03/07 and 03/08 LPN #2 stated that when the Residents BS's were greater than 340 they would call the physician and notify them. LPN #2 stated they would recheck the Residents BS in 1 hour after administering 15 units. When asked if this was documented anywhere LPN #2 stated it should be but it was not.

The surveyor reviewed the nursing entries for the above dates with no documentation regarding BS readings, physician notifications, and/or insulin orders on these days being identified.

The administrative staff was notified of the issues regarding the Residents insulin during a meeting with the survey team on 03/15/17 at approximately 3:15 p.m. and again on 03/16/17 at approximately 10:30 a.m.

On 03/16/17 the nurse consultants at the facility verbalized to the survey team that the facility nursing staff should have contacted the physician and obtained orders for a BS greater than 340. The administrative team also stated they had reviewed all the Resident's orders that were on insulin in the building and re-educated the nursing staff regarding insulin.

Prior to the exit conference the facility staff provided the surveyor with a copy of updated insulin orders for this Resident.

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 371 483.60(i)(1)-(3) FOOD PROCURE, F 371

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| F 371 SS=E | Continued From page 42<br>STORE/PREPARE/SERVE - SANITARY | F 371 | F-371 Storage and Preparation /Sanitation of Food | |

(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, and a facility document review, the facility's staff failed to label, date, and store food in a safe and sanitary manner and failed to document dishwasher temperatures.

The findings included:

The surveyor toured the facility kitchen on 3/14/17 beginning at 1:50 p.m. with other #1 and other #2. During the tour, the surveyor noted in the walk in

Food storage

1. It is the practice of this facility to store, prepare, and distribute foods in a sanitary manner. The 2 bologna and cheese sandwiches were found in the walk-in refrigerator at 1:00 pm, had just been placed there by the cook. Cook labeled and dated them for use at the dinner meal on 3/14/17.
2. All dietary staff were in-serviced on proper storage of sandwiches, labeling and dating on 3/17/17 by the facility dietitian.
3. QA tracking to monitor for proper food storage and labeling is done twice weekly for one month, then weekly for 2 months by the CDM and/or dietitian.
4. CDM or dietitian will review results of food storage audits monthly with the QAPI committee for ongoing monitoring and recommendations.

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| F 371 | Continued From page 43 | F 371 | Dish machine temps | |

refrigerator, ready to eat sandwiches. A total of seven (7) sandwiches were observed. None of the sandwiches were dated. Closer observation revealed there were 2 egg sandwiches, 2 cheese sandwiches, and three bologna sandwiches. One of the two egg sandwiches was labeled, one of the two cheese sandwiches was labeled and none of the bologna sandwiches were labeled. Other #2 stated that "you could tell what they are by looking at them."

The surveyor interviewed dietary aide other #6 on 3/14/17 at 2:00 p.m. The dietary aide other #6 stated when sandwiches were made, the name and date needed to be written on the package. The dietary aide stated the sandwiches were just made.

The surveyor returned to the kitchen to observe the dishwashing procedure on 3/15/17 at 1:25 p.m. The surveyor and other #2 reviewed the dishwasher temperatures for the month of March 2017. The "Dish Machine Temperature Log" for March 2017 had no documentation that the temperatures for wash and rinse and the initials of the person responsible were documented/done for the dinner meal on 3/9/17 and 3/10/17.

The surveyor requested the facility policy on food storage from other #1 and other #2 on 3/14/17 at 2:00 p.m.

The surveyor reviewed the facility policy on "Food Storage" on 3/14/17. The policy read in part "5. Prepared food stored in the refrigerator until service shall be dated with an expiration date. Such food will be tightly sealed with plastic wrap, foil, or a lid."

1. It is the practice of this facility to document dish machine temperatures 3 times per day by dietary staff. On March 9th and 10th, 2017 the dinner dish machine temperatures were not posted on the temperature log. Upon interview of dietary staff on duty those days, the temperatures were checked on March 9th and 10th, confirming that the machine was operating according to manufacturer's requirements.
2. All dietary staff were in-serviced on documenting dish machine temperatures on 3/17/17by the facility dietitian.
3. QA monitoring of temp log will done daily for one week, then weekly for 2 months by the CDM or the dietitian.
4. CDM or dietitian will review results of dish machine temperature log documentation with the QAPI committee for ongoing monitoring and recommendations.

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| F 371 | Continued From page 44<br>The surveyor informed the administrative staff of the above concerns with dating, labeling, and storage of foods and the lack of documentation of dishwasher wash and rinse cycle temperatures during March 2017 in an end of the day meeting on 3/15/17 at 3:15 p.m.<br><br>No further information was provided prior to the exit conference on 3/16/17. | F 371 | | |
| F 431 SS=D | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. | F 431 | F-431 Labeling and storage of Drugs and Biologicals<br><br>1. The locked refrigerator storage box for narcotics on Unit A has been permanently affixed to the refrigerator on 3/16/17 and cannot be removed from the refrigerator.<br>2. The Director of Nursing and Maintenance Director have been in-serviced by the Administrator on 3/29/17 regarding storage of narcotics in a locked permanently affixed refrigerator box.<br>3. Director of Nursing and Maintenance director will visually inspect the refrigerator unit monthly x 3 months to validate unit is permanently affixed.<br>4. Maintenance Director will review results of inspections in Quality Assurance Performance Improvement meeting x 3 months for ongoing monitoring and recommendations. | |

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(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) 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.

(2) 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 and staff interview, the facility staff failed to ensure the narcotic box on 1 of 2 units (unit A) was permanently affixed.

The findings included.

The narcotic box in the refrigerator on unit A was permanently affixed to a shelf but the shelf in which the narcotic box was attached to could be physically taken out of the refrigerator. This narcotic box contained a total of 34 doses of Ativan 2mg/1 ml (2 milligrams per 1 milliter) vials and 4 syringes of Ativan 0.5 mg (milligram) gel for

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| F 431 | Continued From page 46 | F 431 | | |

4 different residents on unit A.

On 3/16/17 at approximately 10 a.m. the surveyor, RN (registered nurse) #2 and the maintenance director entered the medication room on unit A. When checking the refrigerator the surveyor observed a red box attached to a shelf. The staff identified this box as the narcotic box. The surveyor was able to remove this shelf, on which the narcotic box was attached to, from the refrigerator and started walking toward the medication door with the shelf and box in the surveyor's hands. RN #2 and the maintenance director asked the surveyor "where do you think you are going with that." The nursing staff unlocked the box and the surveyor was able to observe the narcotic box which contained a total of 34 doses of Ativan 2mg/1 ml (2 milligrams per 1 milliliter) vials and 4 syringes of Ativan 0.5 mg (milligram) gel for 4 different residents on unit A. When asked if they saw anything wrong with the box the nursing staff replied yes you can remove it from the refrigerator.

On 3/16/17 at approximately 10:45 a.m. the maintenance director verbalized to the surveyor that he had permanently affixed the shelf that the narcotic box was attached to the refrigerator. The maintenance director stated, "it can't be removed now."

The administrative staff were notified of the above documented findings on 3/16/17 at approximately 11 am by the surveyor. The administrative staff member #3 stated, "the shelf has been attached to the refrigerator and the narcotic box cannot be removed from it."

No further information regarding this issue was

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| F 431 | Continued From page 47 provided to the survey team prior to the exit conference on 3/16/17. | F 431 | | |
| F 441 SS=E | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a | F 441 | F-441 Infection Control<br><br>The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of infections.<br><br>1. The dressing for resident # 2was changed on 3/16/17by wound nurse. The Director of Nursing reviewed the infection control log for last 30 days and the entered the dates that the identified infection cleared.<br>2. The Director of Nursing in-serviced the Wound nurse and Unit Managers on completion of the infection control log to include date infection cleared and proper procedure for dressing changes to prevent infection on 3/22/17.<br>3. The Director of Nursing and Unit Managers in-serviced the licensed nurses on dressing changes to prevent infection on 3/27/17. The Director of Nursing /designee will complete a visual observation of dressing changes completed by the wound nurse every other week x 3 months to access competency to perform dressing changes. The Director of Nursing will audit Infection Control logs monthly to validate entry of a date infection has cleared.<br>4. Director of Nursing will review results of dressing change audits and infection control log audits monthly with the QAPI committee for ongoing monitoring and recommendations. | |

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resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure an effective infection control program in regards to tracking of infections and for 1 of 22 residents (Resident #2).

The findings included:

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1. The infection control tracking form provided to the surveyor by the facility was incomplete. The facility had failed to indicate if the infections were resolved or were ongoing.

During the entrance conference with the administrator on 3/14/17, the surveyor asked what staff person was responsible for the tracking of infections. The administrator stated the director of nursing was responsible for infection control.

The director of nursing provided the surveyor with copies of their infection control tracking form and the infection control policy on 3/15/17. Copies of the infection control tracking form were provided for 2016 through February 2017. The director of nursing stated she became responsible for the infection control program in November 2016. However, the document provided to the surveyor was incomplete. Under the column titled "Date Resolved" the document failed to identify if the infection had been resolved or was ongoing for the majority of the residents listed.

The surveyor reviewed the facility infection control policy titled "Infection Control Committee." This policy read in part "The Infection Control Committee (ICC) will meet monthly to oversee the surveillance, investigating, reporting, control, and prevention of infections within the facility. The ICC meeting agenda will include: 2. Review of surveillance reports of infections and infectious disease will be presented to the committee by the Infection Control Coordinator. a. Monthly Infection Control Log (Form 5.1) for individual nursing units is used to track and trend infections by site and organism on a unit. b. The Monthly Report of Facility Infections (Form 5.2)

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-summarizes infection totals for the facility. c. The Quarterly Facility Infection Analysis (Form 5.3)-determines the incidence of residents infected and percentage of infections for the month. Data will be analyzed to identify trends. 6. Current infection control concerns. 7. Changes in regulations, guidelines and recommendations relative to infection to infection control issues."

The surveyor interviewed the director of nursing and administrative staff other #5 on 3/15/17 at 1:40 p.m. Both the DON and administrative other #5 verbalized the incomplete column on the infection control form (column read "date cleared"). Administrative staff other #5 stated that would be easy to fix and stated if a re-culture was done, put that date in the column. If a re-culture was not done, then put the date the antibiotic was completed.

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 3/15/17 at 3:15 p.m.

No further information was provided prior to the exit conference on 3/16/17.

2. The facility staff failed to follow infection control guidelines during wound care observation on Resident #2.

Resident #2 was readmitted to the facility on 11/19/16 with the following diagnoses of, but not limited to anemia, high blood pressure, neurogenic bladder, diabetes, cerebral palsy, paraplegia, seizure disorder, anxiety disorder, depression, and stage IV pressure ulcer. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date)

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of 2/3/17 with a BIMS (Brief Interview for Mental Status, an assessment tool used) with a score of 15 out of a possible score of 15. Resident #2 was also coded as being totally dependent on 2 members for dressing and bathing.

The surveyor went with LPN (Licensed Practical Nurse) #5 to observe wound care being performed on Resident #2's sacral wound on 3/15/17 at 10:20 am. The following was observed by the surveyor during the wound care observation:
LPN #5 washed and dried her hands and applied clean gloves.
Removed the resident's old dressing from the resident's sacral wound.
LPN #5 then removed the old gloves that were now dirty and washed her hands. She then reapplied a new pair of clean gloves.
The area of the wound bed was sprayed with wound cleanser by the nurse and the nurse wiped the wound bed with a clean 4x4 sponge working from the inner to the outer aspects of the wound.
The nurse then opened the packets of skin prep and applied the skin prep to the skin on the resident's bottom bilaterally.
LPN #5 removed her old gloves and washed her hands, applied new gloves and proceeded to perform the wound care as prescribed by the physician.
The surveyor notified the administrative team of the above documented findings on 3/15/17 at approximately 3:15 pm in the conference room.
The surveyor requested a copy of the policy on wound care or dressing changes that the facility has in place for their staff.

At 4:55 pm on 3/15/17, administrative staff member #4 provided the surveyor a copy of the

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| F 441 | Continued From page 52<br>policy titled "Wound and Dressing Care". Under section J, Technique, the following was noted:<br>"1. Clean technique and/or no touch technique may be utilized for wound care dressing changes unless otherwise specified by the Physician. Note to change gloves between the removal of the old dressing and the application of the new dressing<br>2. Clean technique involves strategies used in patient care to reduce the overall number of microorganisms or to prevent or reduce the risk of transmission of microorganisms from one person to another or from one place to another."<br><br>The surveyor interviewed LPN #5 on 3/16/17 at approximately 9:15 am. The surveyor went over how the wound care was performed which was as documented above. LPN #5 stated "I should had taken my old gloves off, washed my hands and put on another pair of clean gloves before I had applied the skin prep. You are right."<br><br>No further information was provided to the surveyor prior to the exit conference on 3/16/17. | F 441 | | |
| F 514 SS=D | 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>(i) Medical records.<br>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete;<br><br>(ii) Accurately documented; | F 514 | F 514 Medical Record Documentation<br><br>The facility must maintain medical records that are complete, accurately documented, readily accessible and systematically organized.<br><br>1. The Social service staff completed a new PASRR for resident # 12 on 3/16/17. The medication orders for resident # 3 were reviewed by Licensed Nurse and clarified route of administration for medications via Enteral feeding tube on 3/23/17. | |

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| F 514 | Continued From page 53<br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 2 of 22 residents (Resident#3 and #12).<br><br>The findings include:<br><br>1. The facility staff failed to ensure an accurate physician recertification order form for Resident #3.<br><br>Resident #3 was admitted to the facility on 2/18/15 with diagnoses of congenital pneumonia, schizophrenia, anxiety, depression, dysphagia, | F 514 | 2. Social Service staff have completed an audit on 3/20/17 of other residents PASARRS to validate completion per documentation guidelines and no use of white out.<br>The Director of Nursing/Designee completed an audit of orders to clarify route of administration of medications or other residents identified enteral feeding tube on 3/23/17. The Administrator in-serviced Social Service staff on 3/29/17 regarding documentation of PASARR including no use of white out.<br>3. The Licensed Nursing staff were in-serviced by The Director of Nursing/Designee regarding MD orders for administering medications to include route of administration on 3/23/17.<br>4. The Director of Nursing/Designee will audit weekly new orders of residents with Enteral feeding tube to validate route of administration of medication is documented in the order. The Social Service Director will audit new PASARRS as they are completed to validate no use of white out. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee x 3 months. | |

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chronic respiratory failure, congestive heart failure, psychosis, chronic obstructive pulmonary disease, hypertension, and anemia.

The significant change Minimum Data Set (MDS) with a reference date of 1/16/17 assessed the resident with a cognitive score of "13" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, hygiene and bathing.

The clinical record was reviewed. The February and March 2017 physician recertification orders were reviewed. Medications were listed as given either by mouth or via G-tube on the orders. The medications ordered by mouth were Ferrous Gluconate, Abilify, Synthroid, Miralax, Xarelto, and Cogentin. The medications listed to give via G-tube were Prilosec, Symmetrel, Caltrate, Aspirin, Klonopin, and Lexapro.

The nurse (LPN#5) administering medication was interviewed on 3/15/17 at 8:00 a.m. LPN#5 was asked how Resident #3's medication were administered. LPN#5 replied that the medications were crushed and administered via G-tube except for Symmetrel which was administered by mouth. LPN#5 stated the Symmetrel capsule was opened and given by mouth. LPN#5 was informed of the physician orders and stated she would clarify the route the medications were to be administered. LPN#5 later stated to the surveyor that all medications were to be administered by mouth.

The administrator, director of nursing, and corporate nurses were informed of the findings during an end of the day meeting with the survey

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team on 3/15/17.
2. The facility staff failed to ensure Resident #12's Pre Admission Screening and Resident Review (PASRR) was accurate. Correction fluid (white-out) was used to correct an incorrect date on the form.

The clinical record of Resident #12 was reviewed 3/14/17 and 3/15/17. Resident #12 was admitted to the facility 7/16/12 and readmitted 1/11/17 with diagnoses that included but not limited to emphysema, chronic airway obstruction, tobacco use, atherosclerosis of the coronary artery, acute MI (myocardial infarction), hypercapneic respiratory failure, pulmonary heart disease, and alcohol dependence.

Resident #12's annual minimum data set (MDS) assessment with an assessment reference date of 1/25/17 assessed the resident with a cognitive summary score of 15 out of 15.

Resident #12's clinical record had a Tennessee Screening for Mental Illness and/or Mental Retardation Pre Admission Screening and Resident Review (PASRR) form. The form had been completed by other #5. Correction fluid had been used to remove the previous date and the date 1/11/17 had been written on the dried correction fluid.

The surveyor showed the director of nursing the PASRR on 3/15/17 at 11:50 a.m. Without asking the director of nursing, she stated to the surveyor white out was used and that the facility doesn't use white out.

The surveyor interviewed other #5 on 3/15/17 at 1:00 p.m. and asked about the use of the

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correction fluid. Other #5 stated she had not written the correct year on the PASRR and had corrected the year with the white out. Other #5 stated she knew not to use it.

The surveyor informed the administrative staff of the above concern during the end of the day meeting on 3/15/17 at 3:15 p.m.

No further information was provided prior to the exit conference on 3/16/17.