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

PRINTED: 02/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495406	A. BUILDING _____ B. WING _____	C 01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	1000 LITTON LANE BLACKSBURG, VA 24060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 01/19/16 through 01/21/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 60 certified bed facility was 49 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #1 through #12) and 4 closed record reviews (Residents #13 through #16).

F 279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS — F 279

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristi L. Blake, LNHA	Administrator	2.26.16

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

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This REQUIREMENT is not met as evidenced by:
Based upon staff interview and clinical record review, it was determined that the facility failed to develop a care plan to address visual function that the CAAs (Care Area Assessment) triggered as being care planned for 2 of 16 residents in the survey sample.
(Resident #1 and #2)

1. Resident #1 was not care planned for visual function.
2. Resident #2 was not care planned for visual function.

The findings included:

1 Resident #1 was readmitted to the facility on 6/29/15 Resident #1 had the following diagnoses of, but not limited to high blood pressure, dementia, arthritis, edema, depression, GERD, seizure disorder and coronary heart disease. Resident #1 ' s MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 7/9/15 coded Resident #1 with a BIMS (Brief Interview for Mental Status) score of 12 out of 15. Resident #1 was also coded as needing extensive assistance by 2 staff members for dressing. Resident #1 was coded as being totally independent in bathing. The resident uses a walker to ambulate in the resident ' s room. Under Section B, B1200: Hearing, Speech and Vison, the resident is coded as having corrective lenses (contacts, glasses, or magnifying glasses). In Section B1000, Vision, Resident #1 was coded as being visional impaired that requires " seeing large print, but not regular print in newspapers/books " .

1. The care plans for residents #1 and #2 were updated to include visual function prior to survey exit on 1/21/16.
2. All residents with a visual impairment have the potential to be effected.
3. The MDS nurses will print the CAT audit report at each full assessment and care plan each triggered area.
4. The MDS nurses will audit 10% of each other's care plans monthly x6 months and report findings to monthly QA.
5. 1/22/16

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Resident #1 triggered Under Section V, on the MDS, the resident triggered under the Care Area for visual function. Under Care Planning Decision on the same MDS, the resident triggered for visual function to be care planned In Section V0200, CAAs and Care planning, it stated the following:

1 " Check column A if Care Area is triggered.
2 For each triggered Care Area, Indicate whether a new care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care plan. The Care Planning Decision must be completed within 7 days of completing the RAI (MDS and CAAs) Check column B if the triggered care is addressed in the care plan .. "

On the admission care plan dated 7/13/15 for Resident #1, there was no care plan that addressed visual function for the resident which would require the resident to use large print to be able to read the new paper or books.

On 1/21/16 at 9:35 am, Registered Nurse (RN) #1 was interviewed in the nurses ' station. RN #1 reviewed the care plan dated for 7/13/15 and stated, " I did not care plan for the resident ' s visual function on here " .

The administrator and director of nursing were notified on 1/20/16 at 4:15 pm in the conference room of the above documented findings of Resident #1 ' s care plan.

No further information was provided to the surveyor prior to the exit conference on 1/21/16

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2 Resident #2 was originally admitted to the facility on 2/10/11 with a readmission date of 11/11/15 Resident #2 had the following diagnoses of, but not limited to, dementia, high blood pressure, psychotic disorder, edema, rectal bleed and depression.

Resident #2 ' s MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 11/23/15 coded Resident #2 with a BIMS (Brief Interview for Mental Status) score of 4 out of 15. Resident #2 was also coded as needing extensive assistance by 2 plus staff members for bathing and requires total dependence on staff for dressing. The resident uses a wheelchair to maneuver in the resident ' s room. Under Section B, B1200: Hearing, Speech and Vison, the resident is not coded as having corrective lenses (contacts, glasses, or magnifying glasses). In Section B1000, Vision, Resident #1 was coded as being moderately which the resident has " limited vision; not able to see newspaper headlines but can identify objects ".

Resident #2 triggered Under Section V, on the MDS, the resident triggered under the Care Area for visual function. Under Care Planning Decision on the same MDS, the resident triggered for visual function to be care planned. In Section V0200, CAAs and Care planning, it stated the following:

1. " Check column A if Care Area is triggered.

2. For each triggered Care Area, Indicate whether a new care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the

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care plan. The Care Planning Decision must be completed within 7 days of completing the RAI (MDS and CAAs) Check column B if the triggered care is addressed in the care plan ... "

On the care plan dated 11/30/15 for Resident #2, there was no care plan that addressed visual function for the resident

On 1/20/16 at 2:25 pm, Registered Nurse (RN) #1 was interviewed in the nurses ' station RN #1 reviewed the care plan dated for 11/30/15 and stated, " I don ' t see it. I looked through all of this " .

On 1/20/16 at 4:30 pm in the conference room, the administrator and director of nursing was notified of the above documented findings of Resident #2 ' s care plan.

No further information was provided to the surveyor prior to the exit conference on 1/21/16.

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

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

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, the facility staff

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failed to follow physician orders regarding the Residents bowel protocol for 6 of 16 Residents (Residents #3, 6, 5, 8, 7, and 2).

The findings included.

1. For Resident #3, the facility staff failed to follow their bowel protocol. Resident #3 had no documented BM's (bowel movements) from 12/23-12/30/15.

Resident #3 was admitted to the facility 01/29/15. Diagnoses included, but were not limited to, constipation, hypertension, hypothyroidism, macular degeneration, anxiety, and chronic pain.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/03/15 had a documented summary score of 9 of 15. Section G (functional status) was coded 3/3 for toilet use and personal hygiene indicating the Resident required extensive assistance of 2 people. Section H (bladder/bowel) was coded 3/2 to indicate the Resident was always incontinent of urine and frequently incontinent of bowel.

Resident #3's CCP (comprehensive care plan) included the concern area of constipation. Interventions included, but were not limited to, ask me each day and record BM's and give me my medicine as ordered.

Resident #3's clinical record included a physician signed POS (physician order sheet) that included orders for docusate (colace) 200 mg (milligrams) everyday for constipation.

The clinical record also included "MEDICAL

1. This event occurred in the past and cannot be corrected.
2. All residents had the potential to be effected.
3. Night shift designee will print out BM report daily. Residents on report will be reviewed for prior interventions and/or need for current interventions as per medical standing orders.
4. DON or designee will review BM reports daily. QA or designee will audit the BM reports weekly x 3 months and report findings to QA monthly.
5. 1/22/16

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STANDING ORDERS" that had been signed by the physician. These orders included the following.
"CONSTIPATION~MOM (milk of magnesia) PO (by mouth) QD (everyday) x 72 hours as needed for no BM in 3 days or c/o (complaints of) constipation from resident. Dulcolax Suppository 10 mg every day x 72 hours as needed for no BM in 3 days or c/o constipation from the resident. Fleets Enema QD PRN (as needed), for no BM in 3 days or c/o constipation from resident."

The surveyor was unable to locate any information in the Residents clinical record to indicate the bowel protocol had been followed by the facility.

On 01/20/16 at 10:55 a.m. the ADON (assistant director of nursing) was notified of the above.

On 01/20/16 at approximately 3:30 p.m. the DON (director of nursing) verbalized to the surveyor that they were unable to locate any information to indicate Resident #3 had a BM during the above timeframe. The DON stated that third shift was responsible for running a BM list for the Residents that had not had a BM. However, she stated she was unable to find any information for December and the reports may have been shredded.

During an end of the day meeting with the survey team on 01/20/16 at approximately 4:15 p.m. the administrator and DON were notified that the facility staff did not follow Resident #3's bowel protocol.

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

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conference.

2. For Resident #6, the facility staff failed to follow their bowel protocol. Resident #6 had no documented BM's (bowel movements) from 12/21/15-12/26/15 and from 01/05/16-01/09/16.

Resident #6 was admitted to the facility 11/10/11. Diagnoses included, but were not limited to, hypertension, Parkinson's disease, dysphagia, dementia, depression, and psychosis.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/02/15 scored the Resident 15 out of a possible 15 points. Section G (functional status) was coded 3/3 for toilet use and personal hygiene indicating the Resident required extensive assistance of 2 people. Section H (bladder/bowel) was coded 2/1 to indicate the Resident was frequently incontinent of urine and occasionally incontinent of bowel. Section I (active diagnoses) included the diagnosis of constipation.

Resident #6's CCP (comprehensive care plan) included the concern area of constipation interventions included, but were not limited to, encourage me to drink more fluids and record BM's.

Resident #6 was receiving senexon-s (senokot-s) 8.6 mg-50 mg (milligrams) 2 tabs twice a day for constipation.

Resident #6's clinical record included "MEDICAL STANDING ORDERS" that had been signed by the physician. These orders included the following.

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"CONSTIPATION-MOM (milk of magnesia) PO (by mouth) QD (everyday) x 72 hours as needed for no BM in 3 days or c/o (complaints of) constipation from resident. Dulcolax Suppository 10 mg every day x 72 hours as needed for no BM in 3 days or c/o constipation from the resident. Fleets Enema QD PRN (as needed), for no BM in 3 days or c/o constipation from resident "

The surveyor was unable to locate any information in the Residents clinical record to indicate the bowel protocol had been followed by the facility for the above timeframe's.

During an end of the day meeting with the survey team on 01/20/16 at approximately 4:15 p.m. the administrator and DON (director of nursing) were notified that the facility staff had not followed Resident #6's bowel protocol.

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

3. Facility staff failed to implement bowel protocol for Resident #5 per physician's orders. Resident #5's clinical record was reviewed on 1/20/16 at 9:00 AM.

Resident #5 was admitted to the facility on 11/23/11. The primary diagnoses included: dementia, hypertension, behavioral disturbances, psychosis and failure to thrive.

The latest MDS (minimum data set) assessment dated 12/28/15 coded the resident with severely impaired cognitive ability. The resident required staff assistance for all the ADLs (activities of daily living.) Resident #5 was coded as totally incontinent of bowel and bladder.

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Resident #5's CCP (comprehensive care plan) updated 12/31/15 addressed the resident's incontinence and ADL requirements. The CCP did not address constipation.

Resident #5 had standing medical orders, signed and dated by the physician on 1/30/11, that included a bowel protocol to address constipation. It was "MOM (milk of magnesia) 30 cc (milliliters) PO (orally) QD (every day) x 72 hrs (HOURS) as needed for no BM (bowel movement) in 3 days or c/o (complaint of) constipation from resident.)

The bowel and bladder report for January 2016 was reviewed. It was observed the resident failed to have bowel movements from 1/1/16 through 1/5/16 (five days) and 1/8/16 through 1/12/16 (five days.)

The MAR (medication administration records) for January did not contain documentation that MOM or other bowel protocol measures were implemented when the resident did not have bowel movements after three days.

On 1/20/16 at 3:30 PM staff were interviewed about tracking bowel movements and implementing the bowel protocol for constipation LPN (licensed practical nurse) I stated, "We're supposed to check the BM (bowel movement) report first thing in the morning. If one of our residents is on it, then we are to begin the bowel protocol that morning with MOM."

RN (registered nurse) I told the surveyor the second shift pulled the BM reports which determined which residents had not had a BM

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during the past nine (eight hour) shifts. That report is left for the first shift to review the next morning--and provide intervention as ordered by the physician for constipation.

The BM sheet was reviewed for January 2016. Resident #5's name appeared on the "NO BM in last nine shifts report" on 1/6/16 and 1/11/16. There was no evidence the nursing staff provided interventions following the review of these reports.

At 3:45 PM the surveyor's findings were shared with the facility DON (director of nursing) She told the surveyor she was going to inservice the nursing staff about reviewing the BM sheets and implementing the bowel protocol for constipation "I'm going to get a copy of the BM sheet myself as well. I'm going to get the second shift to pull the BM list an hour before the shift ends so they can address it (constipation) then."

No additional info was provided prior to exit.

4. Facility staff failed to implement bowel protocol for Resident #8 per physician's orders. Resident #8's clinical record was reviewed on 1/20/16 at 10:00 AM.

Resident #8 was admitted to the facility on 2/2/14. The primary diagnoses included: dementia, hypertension, depression, psychosis and anxiety.

The latest MDS (minimum data set) assessment dated 12/7/15 coded the resident with severely impaired cognitive ability. The resident required staff assistance for all the ADLs (activities of daily living.) Resident #8 was coded as totally incontinent of bowel and bladder.

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Resident #8's CCP (comprehensive care plan) updated 12/7/15 addressed the resident's incontinence and ADL requirements. The CCP did not address constipation.

Resident #8 had standing medical orders, signed and dated by the physician on 3/4/15, that included a bowel protocol to address constipation. It was "MOM (milk of magnesia) 30 cc (milliliters) PO (orally) QD (every day) x 72 hrs (HOURS) as needed for no BM (bowel movement) in 3 days or c/o (complaint of) constipation from resident.)

The bowel and bladder report for January 2016 was reviewed. It was observed the resident failed to have bowel movements from 1/5/16 through 1/8/16 (four days.)

The MAR (medication administration records) for January did not contain documentation that MOM or other bowel protocol measures were implemented when the resident did not have bowel movements after three days.

On 1/20/16 at 3:30 PM staff were interviewed about tracking bowel movements and implementing the bowel protocol for constipation. LPN (licensed practical nurse) I stated, "We're supposed to check the BM (bowel movement) report first thing in the morning. If one of our residents is on it, then we are to begin the bowel protocol that morning with MOM."

RN (registered nurse) I told the surveyor the second shift pulled the BM reports which determined which residents had not had a BM during the past nine (eight hour) shifts. That

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report is left for the first shift to review the next morning--and provide intervention as ordered by the physician for constipation.

The BM sheet was reviewed for January 2016. Resident #5's name appeared on the "NO BM in last nine shifts report" on 1/6/16. There was no evidence the nursing staff provided interventions following the review of this report.

At 3:45 PM the surveyor's findings were shared with the facility DON (director of nursing.) She told the surveyor she was going to inservice the nursing staff about reviewing the BM sheets and implementing the bowel protocol for constipation. "I'm going to get a copy of the BM sheet myself as well. I'm going to get the second shift to pull the BM list an hour before the shift ends so they can address it (constipation) then."

No additional info was provided prior to exit.

5. The facility failed to follow physician ' s order when Resident #7 did not have bowel movements for 3 to more days in a row at multiple times during the resident ' s stay in the facility. Resident #7 was admitted to the facility on 11/5/15 with the following diagnoses of, but not limited to, essential tremors, dizziness, high blood pressure, anemia, constipation and left hip pain. Resident #7 had a MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/11/15. The resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Furthermore, there were no behaviors that were coded under Section E of the MDS. Under Section G, the resident was coded as requiring extensive assistance from 2 or more persons for physical assist with personal hygiene and coded as

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requiring physical help in part of bathing activity.
During the clinical record review 1/20/16 by the surveyor, it was noted on the facility ' s " CORP - Section H Bowel and Bladder Report " dated from 12/22/15 to 1/21/16, Resident #10 had no bowel movements documented on this report for the following dates: 12/22/15, 12/23/15, 12/24/15, 12/25/15, 1/5/16, 1/6/16, 1/7/16, 1/8/16, 1/9/16, 1/10/16, 1/11/16, 1/13/16, 1/14/16, 1/15/16 and 1/16/16. The director of nursing (DON) was made aware of these dates that had no bowel movements documented for the resident. The DON stated, " At the desk a sheet is kept for each resident. The nurses for each shift are to review this and intervene as ordered by the physician " . The surveyor asked the DON if the facility had standing orders for each resident and if they were signed by the physician. The DON replied, " Yes, they do. I will bring a copy for you to have " .
On 1/21/16 at 8:30 am, the DON brought a copy of the " Medical Standing Orders " for Resident #7. Under Constipation, the following standing orders were noted, " MOM 30 cc PO (by mouth) X (times) 72 hours as needed for no BM in 3 days or c/o (complaints of) constipation from resident. Dulcolax Suppository 10 mg (milligrams) every day X 72 hrs as needed for no BM in 3 days or c/o constipation from resident. Fleets enema QD (every day) PRN (as needed), for no BM in 3 days or c/o constipation from resident " .
There was also an order on the MAR (Medication Administration Record) for Resident #7 which stated, " Glycolax 17 G (gram) / Dose powder For> Miralax NF Dissolve 17 gm (grams) in 4-6 oz water and take by mouth prn (which was hand written in on MAR) every day for constipation.
According to the MARs for December, 2015 and January, 2016, there were no interventions as per

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the Medical Standing orders for constipation or for the Miralax that was ordered by the physician on the Plan of care for the same above dates
The surveyor located a book at the nurses ' station that according to the DON, had the list of residents that the nurses were to check each shift to see if the resident had a bowel movement and if they did not, the nurse would assess how many days between bowel movements and intervene as according to the physician ' s orders. For the following dates on all 3 shifts at the facility, Resident #7 was listed as having no bowel movements: 1/5/16, 1/6/16, 1/7/16, 1/8/16, 1/9/16. 1/10/16, 1/13/16, 1/14/16, 1/15/16 and 1/16/16. On these logs, there was no documentation made by the nurses as to if or what interventions were given to the resident for constipation.
The surveyor asked the DON for the reports at the nurse ' s station for the month of December, 2015. The DON replied, " I believe they got thrown away and not kept ".
No further information was provided to the surveyor prior to the exit conference on 1/21/16.
6. The facility failed to follow physician ' s order when Resident #2 did not have bowel movements for 4 consecutive days during the resident ' s stay in the facility.
Resident #2 was originally admitted to the facility on 2/10/11 with a readmission date of 11/11/15. Resident #2 had the following diagnoses of, but not limited to, dementia, high blood pressure, psychotic disorder, edema, rectal bleed and depression.
Resident #2 ' s MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 11/23/15 coded Resident #2 with a BIMS (Brief Interview for Mental Status) score of 4 out of 15. Resident #2 was also

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coded as needing extensive assistance by 2 plus staff members for bathing and requires total dependence on staff for dressing. The resident uses a wheelchair to maneuver in the resident ' s room.

During the clinical record review 1/20/16 by the surveyor, it was noted on the facility ' s " CORP - Section H Bowel and Bladder Report " dated from 12/21/15 to 1/20/16, Resident #2 had no bowel movements documented on this report for the following dates: 12/25/15, 12/26/15, 12/27/15 and 12/28/15. The director of nursing (DON) was made aware of these dates that had no bowel movements documented for the resident The DON stated, " At the desk a sheet is kept for each resident. The nurses for each shift are to review this and intervene as ordered by the physician " . The surveyor asked the DON if the facility had standing orders for each resident and if they were signed by the physician. The DON replied, " Yes, they do I will bring a copy for you to have " .

On 1/21/16 at 8:30 am, the DON brought a copy of the " Medical Standing Orders " for Resident #2. Under Constipation, the following standing orders were noted, " MOM 30 cc PO (by mouth) X (times) 72 hours as needed for no BM in 3 days or c/o (complaints of) constipation from resident. Dulcolax Suppository 10 mg (milligrams) every day X 72 hrs as needed for no BM in 3 days or c/o constipation from resident. Fleets enema QD (every day) PRN (as needed), for no BM in 3 days or c/o constipation from resident " .

According to the MARs for December, 2015, there were no interventions as per the Medical Standing orders for constipation given to the resident during the above documented dates.

The surveyor located a book at the nurses ' station that according to the DON, had the list of

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F 309	Continued From page 16 residents that the nurses were to check each shift to see if the resident had a bowel movement and if they did not, the nurse would assess how many days between bowel movements and intervene as according to the physician ' s orders. The surveyor asked the DON for the report at the nurse ' s station for the month of December, 2015. The DON replied, " I believe they got thrown away and not kept " . No further information was provided to the surveyor prior to the exit conference on 1/21/16.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview, and clinical record review, the facility staff failed to ensure a hazard free environment for 1 of 16 Residents, Resident #11. The findings included. Resident #11's CCP (comprehensive care plan) included the intervention to pad equipment as indicated. The padding on one of the Residents siderail's was torn and partially missing. Resident #11 was admitted to the facility	F 323		

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02/09/06. Diagnoses included, but were not limited to hypertension, anemia, depression, and severe dementia.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/02/15 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. Section G (functional status) was coded 3/3 in the areas of bed mobility and transfers to indicate the Resident required extensive assistance of two people. Range of motion was coded 1/0 to indicate the Resident had limitations on one side of the upper extremity and none in the lower.

The Residents clinical record included the following documentation-09/11/15 0600 (6:00 a.m.) "During morning medication administration, this RN (registered nurse) noted that resident has a large (3 cm (centimeter) wide X 3 1/2 cm long), bruised area & hematoma located to the middle of her forehead. The goose egg is tender to the touch. Ice pack applied to resident's forehead." The facility staff had documented at 7:00 a.m. that the DON (director of nursing), administrator, MD (medical doctor), and family had been notified.

The Resident had been seen at the facility by the (PA) physician's assistant on 09/14/15. The PA had documented "...Patient seen today for "knot" on her forehead Apparently her head was lightly brushed against the bedrail when she was being turned...Neuro was wnl (within normal limits) after i presume a hematoma developed on forehead THere is no lesion there now, just a small bruise

1. This was corrected at the time of observation.
2. All residents with facility padded equipment have the potential to be effected.
3. During monthly safety audit, residents with facility padded equipment will be assessed for needed repairs. Work orders will be completed for any items in need of correction.
4. QA or designee will audit submitted work orders for completion monthly for 6 months and will submit to QA.

5. 1/22/16

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Monitor."

Resident #11 had been a focus of an APS (adult protective service) investigation due to the "bruise/hematoma" located in the center of the forehead. The investigation was unfounded for any abuse and/or neglect. However, the report indicated that the facility "...took measures to pad the bed control which they thought could possibly have caused the injury."

The Residents CCP included the intervention to pad equipment as indicated.

On 01/21/16 at approximately 9:30 a.m. the surveyor entered the Residents room. Resident #11 was observed to be resting on her bed. The 1/2 siderail near the window was padded. However, the 1/2 siderail closest to the door was torn and partially missing exposing a large portion of the siderail. The Resident was observed to have a discolored area to the left side of her chin. This was the side that part of the padding was missing.

The clinical record included a nursing entry dated 01/13/16 at 3:00 a.m. "Late entry for 1-12-16 @ 2200 (10:00 p.m.) CNA (certified nursing assistant) reported to this nurse bruise to resident's left corner of mouth/chin area. This nurse assessed 3 cm X 1 cm bruise to area dark purple/blue in color. No signs of pain. MD notified." The clinical record included further documentation to indicate the family was made aware of the bruise.

On 01/21/16 at approximately 9:35 a.m. the surveyor and the ADON (assistant director of nursing) entered Resident #11's room. The ADON

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F 323	Continued From page 19 was shown the torn/missing padding. The ADON stated that's "not good enough..." referring to the padding and stated she would call maintenance and put in a work order. On 01/21/16 at approximately 10:40 a.m. the surveyor observed maintenance personnel #1 in the Residents room replacing the missing/torn padding. During an onsite interview with the Residents POA (power of attorney) on 01/21/16 at approximately 11:55 a.m. the POA verbalized to the surveyor that they were satisfied with the Residents care at the facility and stated the Resident bruised easily. The administrator and DON (director of nursing) were notified of the above in a meeting with the survey team on 01/21/15 at approximately 1:20 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 323		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) 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. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425		

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acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident & staff interview, facility document review, clinical record review and in the course of a complaint investigation it was determined the facility staff failed to collaborate with the pharmacy to ensure medication availability for 3 of 16 residents (12, 13, 1) and to ensure disposal of outdated glucometer and coagulation/PT strips stored in the medication room.

~Resident #13 - failed to obtain intravenous antibiotics on admission.
~Resident #12 - failed to obtain Refresh tears and Timolol drops.
~Resident #1 - failed to obtain Lortab.

Findings:

1. Facility staff failed to obtain and administer intravenous antibiotics (Nafcillin) ordered by the physician for Resident #13's admission. The closed clinical record was reviewed on 1/20/16 at 1:00 PM.

Resident #13 was admitted on 11/1/14. The

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resident's diagnoses included: Aftercare Post right knee arthroplasty, stage I revision and infection right knee.

The MDS (minimum data set) assessment date 11/16/14 coded this resident as completely intact cognitively. The resident required assistance with the ADLs (activities of daily living) due to his post surgical state. The resident was continent of bowel and bladder.

The resident's CCP (comprehensive care plan) implemented 11/10/14 noted the problem of "right knee replacement because of infection.....now receive IV (intravenous) antibiotic therapy " The interventions included "Give me my IV medications as ordered."

Resident #13's admission orders for intravenous antibiotic therapy were signed and dated electronically by the discharging orthopedic physician at the hospital on 11/1/14. They were faxed to the facility prior to the resident's arrival. The orders included, "nafcillin (Nafcill) 2 grams/100 ml (milliliters) piggyback. 2 g by intravenous route every four hours. Start date: 11/1/2014, End date: 12/10/2014."

The physician's orders were received and transcribed in hand by a staff nurse (RN I) on 11/1/14 as admission orders. These initial admission orders were signed and dated by the facility physician on 11/9/14. These orders included, "Nafcillin 2 grams/100 ml IV Q 4 hours....R total knee revision. The administration times were 0200, 0600, 1000, 1400, 1800, & 2200."

Nursing note documentation indicated Resident

4. During monthly safety audit, QA or designee will inspect the medication room for outdated products and will discard at time of audit. The DON will submit monthly pharmacy list of expired prescriptions to QA for 6 months. The QA department or designee will audit 10% of resident MARs for delay in receipt or availability and report any out of 24-hour compliance findings to QA.

5. 1/22/16

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#13 was admitted to the facility on 11/1/14 at 3:15 PM. His first antibiotic dosage should have been provided at 1800 (6:00 PM) and every four hours thereafter

The MARs (medication administration records) for November and December 2014 were reviewed. Resident #13's first dose of the intravenous antibiotic, Nafcillin, was administered on 11/2/14 at 1400 (2:00 PM) The nursing staff failed to provide six intravenous administrations of Nafcillin.

The clinical record contained a telephone order obtained from Resident #13's physician on 11/2/14 at 1930 (7:30 PM.) The order stated: "Late entry: Hold Nafcillin 2g/100ml IV until 11/2/14 at 1400 (2:00 PM.)" (This order was obtained five hours after the antibiotic was obtained and initially administered.)

On 1/20/16 at 3:30 PM the facility DON (director of nursing) was asked to provide information as to why the facility staff had not begun administration of the antibiotic as ordered by the physician. The DON said the medication list was faxed to the pharmacy (11/1/14 at 1:27 PM) by nursing staff prior to the resident's admission--but a page was missing from the fax. This caused a delay in the delivery from the pharmacy.

When the DON was asked if the antibiotic could have been obtained from the local back-up pharmacy she said that was a good question. The DON did not know the name of the local back-up pharmacy or how to coordinate the order if medications needed to be obtained STAT (immediately) from the back-up. She suggested the surveyor discuss that with a medication nurse

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PRINTED 02/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495406	A. BUILDING _____ B. WING _____	C 01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	1000 LITTON LANE BLACKSBURG, VA 24060

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who would be familiar with the procedure.

On 1/21/16 at 9:50 AM RN I was interviewed regarding the acquisition of medications from the pharmacies. RN I said if she did not have a medication available for administration she would first check the STAT box to see if they had it in stock. If not, then she would let the doctor know and call the RX (primary pharmacy) for a STAT run to get the medication here for timely administration.

RN I stated, "If the RX cannot get it here, it's possible to try the (name of local back-up pharmacy.) They can send it right over in a taxi. They (primary pharmacy) don't always do it because there's an extra charge. They (primary pharmacy) will call the back-up, but we have to request critical meds from back-up ourselves."

At 10:00 AM RN II was asked about the procedure and timeliness of obtaining medications from the pharmacies. RN II stated, "We still have to call our (primary) pharmacy and they contact the back-up (local) pharmacy. We do have to ask them to call the back-up if medication doesn't get here in a timely manner in the allotted time for administration. It's not usually an issue."

At 10:15 AM LPN I was interviewed regarding same. "If I don't have a medication when time comes for administration, I notify the physician and get his order after calling the pharmacy for a STAT run. It usually takes 1-2 hours for a STAT run. If it's longer, we can request the back-up pharmacy send it. They bring it right over--usually less than an hour."

On 1/21/16 at 2:00 PM the administrator and

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DON were informed of the surveyor's findings. No additional information was provided prior to the survey team exit.

This was a complaint deficiency.

2. Facility staff failed to obtain and administer Timolol and Refresh tears eye drops for Resident #12. Resident #12's clinical record was reviewed on 1/20/16 at 2:00 PM.

The resident was admitted to the facility on 1/23/13. Her current diagnoses included spinal stenosis, depression, anxiety, glaucoma, and trigenial neuralgia.

The latest MDS assessment, dated 10/20/15, coded the resident as cognitively unimpaired. She needed little more than nursing oversite for the ADLs, with a minimal assist in bathing and personal hygiene. The resident was continent of bowel and bladder. The vision was coded as moderately impaired and corrected by the use of eye glasses.

The resident's CCP, reviewed on 10/25/15, addressed the resident's desire to remain as independent as possible and perform with as little help from staff as possible. The interventions for this goal included, "Please follow pharmacy directions for my eye drops."

Resident #12's physician orders, signed and dated 1/6/16 included two orders for eye drops:
1. "Timolol maleate 0.5% drops....instill 1 drop into left eye every morning for glaucoma - press tear duct for one minute or close eyes for 3 minutes after administration."
2. "Refresh tears 0.5% drops instill 1 drop into

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both eyes 6 times a day for dry eyes." Administration times were 0600, 1000, 1200, 1400, 1700, & 2000.

On 1/20/16 at 10.30 AM Resident #12 was interviewed during a group council meeting. She told the surveyor that the nursing staff did not always have her medications stocked when time came to administer them. Resident #12 stated, "I've asked them why they wait until I run out of something before they order it from the pharmacy. It would make more sense to order it when it started running low--that way I wouldn't miss doses."

The resident said the facility had never run out of her pain medicine--but had run out of her eye drops on several occasions. The resident said she had glaucoma in one eye and suffered from chronic dryness in both eyes. "I've had a lot of problems with my eyes, and several infections."

Resident #12's MARS (medication administration records were reviewed for the past year since the last survey. Three separate occasion were found when the staff ran out of the resident's eye drops and held them until the pharmacy could refill them:
1. 4/14-21/15 - The nursing staff omitted 8 days and 8 doses of the resident's Timolol for glaucoma
2. 11/17/15 - The nursing staff omitted 5 doses for the resident's Refresh Tears for dry eye.
3. 12/17/15 - The nursing staff omitted 3 doses for the resident's Refresh Tears for dry eye.

On 1/20/16 at 3:30 PM the facility DON (director of nursing) was asked to provide information as to why the facility staff had not reordered the eye

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drops in a timely fashion so they would be available for administration uninterrupted. The DON agreed they should have been reordered and available.

On 1/21/16 at 9:50 AM RN I was interviewed regarding the acquisition of medications from the pharmacies. RN I stated, "If the RX (primary pharmacy) cannot get it here, it's possible to try the (name of local back-up pharmacy.) They can send it right over in a taxi. They (primary pharmacy) don't always do it because there's an extra charge. They (primary pharmacy) will call the back-up, but we have to request critical meds from back-up ourselves."

At 10:00 AM RN II was asked about the procedure and timeliness of obtaining medications from the pharmacies. RN II stated, "We still have to call our (primary) pharmacy and they contact the back-up (local) pharmacy. We do have to ask them to call the back-up if medication doesn't get here in a timely manner in the allotted time for administration. It's not usually an issue."

At 10:15 AM LPN I was interviewed regarding same. "If I don't have a medication when time comes for administration, I notify the physician and get his order after calling the pharmacy for a STAT run. It usually takes 1-2 hours for a STAT run. If it's longer, we can request the back-up pharmacy send it. They bring it right over--usually less than an hour."

On 1/21/16 at 2:00 PM the administrator and DON were informed of the surveyor's findings. No additional information was provided prior to the survey team exit.

3. The facility failed to have physician ordered

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pain medication available for Resident #1 ' s use during the resident ' s stay in the facility.
Resident #1 was readmitted to the facility on 6/29/15. Resident #1 had the following diagnoses of, but not limited to high blood pressure, dementia, arthritis, edema, depression, GERD, seizure disorder and coronary heart disease.
Resident #1 ' s MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 7/9/15 coded Resident #1 with a BIMS (Brief Interview for Mental Status) score of 12 out of 15. Resident #1 was also coded as needing extensive assistance by 2 staff members for dressing. Resident #1 was coded as being totally independent in bathing. The resident uses a walker to ambulate in the resident ' s room.
Under Section J, in the same MDS as stated above, the resident reports that to the interviewer that the resident has had pain or hurting over the past 5 days. In Section J0400, the resident was asked, " How much of the time have you experienced pain or hurting over the past 5 days? " The resident was coded as a " 1 " which is " almost constantly ". In Section V, pain is triggered as being care planned for this resident.
In the care plan dated 7/13/15 for Resident #1, pain was addressed in the care plan with interventions put into place.
During further chart review of Resident #1 ' s clinical record on 1/20/16, it was noted by the surveyor that the following physician order was written as a telephone or verbal order " 9/30/15 at 1525 (3:25 pm) Hold 2000 (8 pm) Norco (previously prescribed pain medication) til available from Pharmacy. Tylenol 650 mg (milligram) po (by mouth) q (every) 4 hours prn (as needed) for 72 hours pain ". On the narcotic sign out sheets for Resident #1 ' s prescribed

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Norco, the last entry on the narcotic sheet dated from 8/16/15 to 9/29/15 was an entry on 9/29/15 at 2000 in which the nurse signed out for 1 tablet of Norco 5/325 mg to be given to the resident at that time. The next entry on the narcotic count sheet for Norco 5/325 mg was on 10/2/15 in which the nurse signed in as receiving 30 tablets of this medication for Resident #1 at 7:10 am
The next entry was on 10/2/15 at 1915 (7:15 pm) in which the nurse signed out for 1 tablet of Norco 5/325 mg to be given to the resident. And again another entry for the same medication and strength was signed out by the nurse at 2000 for the medication to be given to the resident.
According to the clinical record review from the time Resident #1 was admitted to the facility, the Plan of Care of physician ' s orders dated from 7/1/15 until 10/31/15, it was noted that the pain medication " Norco 5/325 mg 1 tablet po every 6 hours prn and at bedtime " had been ordered by the physician.
On 1/21/15 at 1 pm in the conference room, the administrator and director of nursing (DON) was informed of the unavailable Norco for Resident #1. The DON stated, " I ' m unaware of any back up pharmacy that we could have used in this situation. But I will look into this " .
At 1:45 pm in the conference room, the DON brought in the list of contents in the control box that staff can use. The DON stated, " The staff has to call the pharmacy and get the code that will open the stat control box and then they can take the medication out of the box after they fill out the appropriate paperwork for it. I cannot tell if the Norco that was needed was taken out of the stat box. The pharmacy has the slips that the staff has to fill out " . The surveyor reviewed the list of contents of the stat control box and found that Norco 5/325 mg times 2 tablets.

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No further information was provided to the surveyor prior to the exit conference on 1/21/16
4 The facility failed to discard expired bottles of glucose monitoring strips and Prothrombin Time test strips that was found in the medication room. Upon entrance to the facility on 1/19/16, the surveyor inspected the Medication Room that is used for the Cove portion of the facility
According to the assistant director of nursing, this is the only medication room that the staff uses
At 3:55 pm on 1/19/16 in the medication room, the surveyor noted a bottle of CoaguChek Prothrombin time test strips that were out of date
The lot number for this bottle was 219-118-12 with a code of 482 and a reference number of 04625315-160 The assistant of nursing was with the surveyor when this bottle was found on the wire rack with the other supplies for this testing that can be performed on any resident in the facility that receives a blood thinner
On 1/19/16 at 4:10 pm in the medication room, the surveyor noted the following items that were out of date. The following items were located on the wire rack in the medication room: 6 bottles of Microdot test strips for glucose monitoring machine (this machine determines by blood obtained by a finger stick of what a resident ' s blood sugar is) and 1 bottle of Prothrombin Time test strips used to determine how thin a resident ' s blood is when they are taking a blood thinner
The following bottles of Microdot test strips had the following on the bottles.

1. Lot number 3030503 Expiration date 3/15
2. Lot number 01164C Expiration date 8/15
3. Lot number 04174C Expiration date 11/15
4. Lot number 04174C Expiration date 11/15 (This bottle was in an unopened box)
5. Lot number 04174C Expiration date

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11/15 (This bottle was in an unopened box)
6 Lot number 04303A Expiration date 4/15 (This bottle was in an unopened box)
The assistant director of nursing came into the conference room at 4:30 pm on 1/19/16 and stated, " Every resident has their own glucometer and strips in a plastic bag on each medication cart. We don ' t use the ones you found anymore. They should had been thrown away "
On 1/20/16 at 4:30 pm in the conference room, the director of nursing and administrator was notified of the above documented findings of the expired bottles of glucose and Prothrombin time monitoring strips.
On 1/21/16 at 11 am, the director of nursing brought into the surveyor the policy titled " Blood Sugar Monitoring (Finger stick) and the package insert for the the " CoaguCheck XS PT (Prothrombin Test) " . In the policy for the Blood Sugar Monitoring, it stated the following:
. 10. " Control solution testing is to validate that the EvernCare G3 is working properly with the test strips. Control solution testing should be performed when. Using the meter for the first time. Using a new bottle of ....test strips ... "
The director of nursing also presented the operating manual for the " EvenCare G3 " machine According to page 13 in the operating manual, the following statement was noted by the manufacturer: " ...Check the expiration date printed on the test strip bottle. DO NOT use expired test strips ... " .
The package insert for the " CoaguChek XS PT Test " was also brought to the surveyor by the director of nursing. Under the section " Storing the Test Strips " the following was stated. " ...When stored properly the test strips can be used until the expiration date printed on the test strip container. Discard the test strips if they are

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F 425	Continued From page 31 past the expiration date on the container ... ". No further information was provided to the surveyor prior to the exit conference on 1//21/16.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	1. This occurred in the past and cannot be corrected. 2. All residents had the potential to be effected. 3. Night shift nurses will review each chart for new orders daily and will verify for accuracy of transcription to the MAR. 4. QA department or designee will audit 10% of resident records monthly x 6months.	5. 1/22/16

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transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review the facility staff failed to maintain an infection control program to help prevent the development and transmission of disease.

The findings included.

On 01/19/16, during the entrance conference, the administrator and DON (director of nursing) were asked to provide the surveyor with the infection control line list (infection control tracking form) for November 2015, December 2015, and January 2016.
When the documents were provided to the surveyor they were incomplete. The documents did not identify any organism if applicable, if the infection was acquired at facility or if the Resident had been admitted with the infection, and did not identify if the infection had been resolved or was ongoing.
The facility staff were documenting non infectious diseases such as calmoseptine for prevention and desitin cream for excoriation on the same form.
After reviewing the documents provided by the facility the surveyor requested the infection control policy.
On 01/20/16 at approximately 4:10 p.m. the administrator provided the surveyor with a copy of their policy titled "Infection Control Program". This policy read in part "A. The infection control program for _____ (name of facility) will provide

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safe, sanitary and comfortable environment that promotes the prevention and/or development and transmission of disease and infection ."
The surveyor was unable to interview the infection control nurse as she was not working during the time of the survey. The DON identified herself as the infection control nurse for the purpose of the survey.
On 01/21/16 at approximately 10:00 a.m. the surveyor interviewed the DON and assistant SDC (staff development coordinator). When the DON was asked about the non-infectious diseases that had been documented on the forms she stated that they were already being tracked by the former DON and she had not changed it. The DON stated that a weakened area of skin could lead to a fungal infection. The DON then added that in the recent QA (quality assurance) meeting the committee had decided to remove these from the tracking log.
The DON stated that they had previously tracked the organisms in regards to urinary tract infections, wound cultures (if ordered by the physician), nasal swabs, flu, and stool. But they never found any correlation or trends so they had stopped collecting the information.
When asked about clearing or resolving the infections. The DON stated that they only retested if the Resident was symptomatic
The DON stated the unit secretary was responsible for inputting the information and then it was sent to staff development whenever someone was added.
The administrator and DON were notified of the incomplete tracking regarding infections during a meeting with the survey team on 01/20/16 at 4:15 p.m. and again on 01/21/16 at 1:20 p.m.
According to the CDC (centers for disease control) "...when facilities track infections, they

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F 441	Continued From page 34 can identify problems and track progress toward stopping infections..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments, the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based upon staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for 1 of 16 residents in the survey sample (Resident #10). The findings included: The facility staff failed to put the correct physician order for Miralax on the Plan of Care which was dated 11/1/15 to 11/30/15 for Resident #10. Resident #10 was admitted to the facility on 2/28/13 and had a reentry to the facility on 3/19/13. Resident #10 has the following diagnoses of, but not limited to mild mental	F 514		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495406	A. BUILDING _____ B. WING _____	C 01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	1000 LITTON LANE BLACKSBURG, VA 24060

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F 514	Continued From page 35	F 514		

retardation, GERD, depression, allergies, arthritis, constipation, chronic obstructive pulmonary disease, low potassium levels and diabetes.
According to the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/7/15, the resident was coded as having a BIMS (Brief Interview for Mental Status) of 15 out of a possible score of 15. Resident #10 was also coded as needing extensive assistance with a one person assist in personal hygiene and bathing.
During the chart review on 1/21/16 by the surveyor, it was noted that the following verbal/telephone order was in chart and signed by the physician. The order was dated and timed for 10/25/15 at 8:30 am and stated: " Change Miralax to mix 17 grams in 4 oz (ounces) of H2O (water) via (by) peg tube QD (every day) prn (as needed) (constipation) ". On the Plan of Care dated for 11/1/15 to 11/30/15, the following order was noted: " Polyethylene Glycol 17 GM (gram) / 1 dose of powder for> Miralax NF mix 17 grams in 8 ounces of water and take via peg tube every other day (the every other day was marked out) and prn (as needed) was hand written in for constipation ".
The director of nursing (DON) was notified of the above documented findings on 1/21/16 at 11 am in the conference room. The DON stated, " that order was not carried over to the plan of care for this resident as it was previously written on 10/25/15 ".
No further information was provided to the surveyor prior to the exit conference at 2:15 pm on 1/21/16.