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

PRINTED: 03/14/20
FORM APPROVI
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495401	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYLER'S RETREAT AT IRON BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/28/17 through 3/2/17. A 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 90 certified bed facility was 87 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents #1 through #15 and #22) and six closed record reviews (Residents #16 through #21).	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157	**F 157 SS=D** The facility will ensure that the physician is notified of changes in resident's condition. **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #7's physician was notified of blood pressure outside of parameters on 3/1/17. MD did not give any new orders. b. Resident #7's physician was notified of her weight and gave a new order for weights x 3 days. **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. Residents with Blood Pressure parameters will have their charts reviewed by the RN Unit Manager / designee to ensure MD order parameters are being followed and MD is notified.	3/31/17 3/31/17 3/31/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda C. Kran — TITLE: Administrator — (X6) DATE: 3-29-17

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

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F 157	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to notify the physician of a change in a resident's condition for one of 22 residents in the survey sample, Resident #7. a. The Facility staff failed to notify the physician when Resident #7's systolic blood pressure was higher than 150 as ordered by the physician. b. The Facility staff failed to notify the physician of	F 157	b. Residents found with Blood Pressures out of Parameters will have their MD notified by a licensed nurse with follow up as appropriate. c. All residents with orders for weights will have their weights reviewed by the RN Unit Manager and any variation of 5lbs plus or minus will have a reweight and interventions put into place per the registered dietician/ Physician. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. Licensed Nurses will be in-serviced on Change in Resident condition, notification of physician policy and reweight policy by Director of Nursing / Designee by 4-1-17. **4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. RN Unit Manager / designee will audit 5 MAR's with parameters and/or weights for MD notification per week for 4 weeks and then monthly for 2 months. b. Unit Managers will report the results of the audits to the QAPI committee monthly for 3 months. c. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	3/31/17 3/31/17 4/1/17 4/14/17 4/14/17 4/14/17

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a 15 pound weight gain over a three day period for Resident #7.

The findings include:

a. Resident #7 was admitted to the facility on 3/5/14 and readmitted on 1/25/17 with diagnoses that included but were not limited to: arthritis, fractured leg, dementia, high blood pressure and elevated cholesterol.

The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 2/8/17 coded the resident as having scored an 11 out of 15 on the brief interview for mental status indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident was coded as able to do after the meal tray was prepared.

Review of the physician's orders dated 2/8/17 documented, "B/P (blood pressure) Q (every) shift Call MD (medical doctor) if SBP (systolic blood pressure) > (greater than) 150 and if DBP (diastolic blood pressure is > 90."

Review of the care plan initiated on 1/26/17 did not evidence documentation related to the blood pressures.

Review of the February 2017 TAR (treatment administration record) documented, "B/P Q Shift -- call MD if SBP > 150 and if DBP > 90. 2/8/17."

Review of the TAR documented the following blood pressures:
2/9/17 -- "7-3 (7:00 a.m. to 3:00 p.m.) 190/80"

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F 157	Continued From page 3 2/9/17 -- "11-7 (11:00 p.m. to 7:00 a.m.) 170/68" 2/11/17 --"11-7 155/63" 2/14/17 -- "11-7 154/74" 2/17/17 -- "11-7 160/80" 2/19/17 -- "7-3 155/74" 2/25/17 -- "7-3 171/62" 2/27/17, --"7-3 166/65" 2/28/17 -- "11-7 156/73." Review of the February 2017 nurses' notes for Resident #7 did not evidence documentation that the physician had been notified of the elevated blood pressures. An interview was conducted on 3/1/17 at 2:10 p.m. with RN (registered nurse) #6, the unit manager. RN #6 reviewed Resident #7's February 2017 TAR for the blood pressures. When asked if it would it be documented when the physician was notified, RN #6 stated it would be. RN #6 reviewed the February 2017 nurses' notes. RN #6 stated, "No, they didn't call the doctor." On 3/1/17 at 4:45 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. An interview was conducted on 3/2/17 at 10:55 a.m. with RN #7. regarding when staff would notify the physician, RN #7 stated, "Practically everything. If there is a change in their condition, they're not feeling well, if there's a fall." When asked about the process followed by staff if a physician ordered to be notified for an elevated blood pressure, RN #7 stated, "Whenever you have parameters you must check the blood pressure." When asked to review Resident #7's	F 157		

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February 2017 TAR's for the blood pressures, RN #7 stated, "Yes I would call and let them (physician) know." When asked if that notification to the physician would be documented, RN #7 stated, "Absolutely. You're supposed to document everything." When asked why, RN #7 stated, "It's important because that's continuity of care. Anyone following you gets a clear picture of what's going on."

An interview was conducted on 3/2/17 at 11:30 a.m. with ASM (administrative staff member) #4, the nurse practitioner. When asked why she would order blood pressure parameters on a resident, ASM #4 stated, "Typically, I personally, would order those if I'd changed a medication. Also if they've come out of the hospital their medications are usually changed. As they recover things are going to normalize and they may need the medication back."

An interview was conducted on 3/2/17 at 12:35 p.m. with LPN (licensed practical nurse) #6, regarding when staff would notify the physician, LPN #6 stated, "High blood pressure, low pressure. Any change in condition." When asked if staff would document that the physician was notified, LPN #6 stated, "I document it in the nurse's notes and on the 24 hour report." When asked why she documented the notification, LPN #6 stated, "Because they have parameters for a reason. The doctor may need to increase the dosage (of a medication). Something could be going on with them, they could have an infection."

Review of the facility's policy titled, "Change in Resident Condition" documented, "The Charge Nurse will recognize and appropriately intervene in the event of a change in resident condition.

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The Physician/Family/Responsible party will be notified as soon as the nurse has identified the change in condition and the resident is stable....PROCEDURE: 7. The clinical nurse will record in the resident's clinical chart information relative to changes in the resident's medical/mental condition or status."

No further information was provided prior to exit.

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. The physician or health care provider is responsible for directing the medical treatment of a patient.

1.b. Review of the physician's orders dated 1/25/17 documented, "Wt (weigh) Q (every) Day X (times) 3 days than (sic) wt Q wk (week) X 4 wks."

Review of the care plan initiated on 2/1/17 documented, "Focus Resident has potential for altered nutritional status...Interventions Weight per facility protocol...Date initiated: 03/21/2014."

Review of the January 2017 TAR documented, "Wt. QD (everyday) X 3 days." On 1/26/17 a weight of 126 pounds was documented. On 1/27/17 no weight was documented, on 1/28/17 a weight of 141 pounds was documented. A 15 pound weight gain.

Review of the nurse's notes for 1/28/17 through 1/30/17 did not evidence documentation regarding physician notification of the weight gain.

An interview was conducted on 2/28/17 with RN

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F 157	Continued From page 6 #6, the unit manager. RN #6 was asked to review the above weights. After reviewing the weights, RN #6 stated, "She should have did (sic) a re-weight. Then they should have notified the doctor and the family and they probably should have told me." An interview was conducted on 3/1/17 at 10:55 a.m. with RN #7. When asked why residents were weighed, RN #7 stated, "We do it for nutrition to monitor for weight loss." When asked to review Resident #7's January 2017 TAR, RN #7 stated, "It's a big flag (the weight gain). We should have re-weighed (the resident). If they gain more than three pounds in a day or five pounds in a week we would notify the doctor. Maybe it's addressed in the notes." RN #7 reviewed the nurse's notes, and RN #7 stated, "I don't see anything." An interview was conducted on 3/1/17 at 11:00 a.m. with LPN #5, the resident's nurse. When asked to review the TAR, LPN #5 stated, "I would notify the doctor because not all of the weights were done and that's a big jump from 126 to 141." On 3/1/17 at 4:45 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.	F 157		
F 256 SS=E	483.10(i)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS (i)(5) Adequate and comfortable lighting levels in all areas; This REQUIREMENT is not met as evidenced by:	F 256		

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F 256	Continued From page 7 Based on observation, resident interview, and staff interview, it was determined that the facility staff failed to provide adequate lighting to meet the resident's individual needs for four of 22 residents in the survey sample, Residents #2, #12, #13 and #22. 1. Resident #2's lamp in the room was observed with the lamp shade removed and on interview Resident #2 stated there was not enough light in the room that's why we have the lamp shades off, to give more light. Resident #2 stated she was unable to read in her room due to the lighting. 2. Resident #12 was observed in her room attempting to read her mail and on interview stated there was not enough light in the room. Resident #12's lamp in the room was observed with the lamp shade removed and on interview Resident #12 stated we took them (the lamp shade) off to add light but then they (the lights) get too hot so we have to turn them off. 3. For Resident # 13, the facility staff did not provide adequate lighting in the Resident's room. 4. For Resident # 22, the facility staff did not provide adequate lighting in the Resident's room. The findings include: 1. Resident #2 was admitted to the facility on 3/15/16 with a recent readmission on 12/30/16 with diagnoses that included but were not limited to: muscle weakness, spinal stenosis (an abnormal narrowing of the spine) (1), scoliosis (abnormal lateral or sideward curve to the spine) (2), osteoarthritis (degenerative changes in the joints) (3) paraplegia (paralysis of the lower limbs)	F 256	**F 256** **SS=E** The facility will ensure that residents have adequate lighting to meet their individual needs. **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** a. Residents #2, #12 and #13 had new "9 watt / 60 watt LED daytime" light bulbs placed in their light fixtures in their rooms by the Maintenance Director on 3/2/17. Each resident reported that the lighting was adequate to meet their needs. b. Resident #22 was offered the new lights by the Maintenance Director and stated "I am fine just like I am". **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. Residents will be interviewed by assigned Department and Nurse Managers to determine whether they feel the lighting is adequate in their room and whether they would like the new brighter bulbs. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. Maintenance Director will replace current light bulbs of residents who request the LED daytime bulbs and use the LED daytime bulbs to replace current bulbs as they burn out. b. Residents will be asked during Resident Council by the Activity Director / designee whether they feel the lighting is adequate in their rooms monthly for 3 months and at least quarterly for a year.	3/2/17 3/2/17 3/31/17 4/14/17 4/14/17

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F 256	Continued From page 8 (4), insomnia and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/3/17, coded the resident as being cognitively intact to make daily decisions. The resident was totally dependent upon the staff for all transfers, moving in the bed, and toileting. She required extensive assistance for personal hygiene, dressing and bathing. Resident #2 was coded in Section B1000 - Vision as having the ability to see in adequate light. In Section B1200 - Corrective lenses, the resident was coded as wearing glasses used to completing B1000. She was independent to move around the facility in a motorized wheelchair. Resident #2's comprehensive care plan did not address vision. Observation was made of the resident room on 2/28/17 at 3:25 p.m. The room was noted to have two overhead lights, one at the entrance and one between the foot of the two beds. Resident #2 resided in the bed closest to the door. The room appeared poorly lit. There was a lamp on each of the two night stands. The lampshades were off and observed on the top of the closets. The Resident Interview was initiated. When asked if there was enough lighting in the room, Resident #2 stated, "No, that's why we have the lamp shades off, to give more light. Then we have to turn them off because it gets too hot with them on." When asked if she had enough light to read, Resident #2 stated, "No, if I didn't have a Kindle, I wouldn't be able to read a book." A second interview was conducted with Resident #2 on 3/2/17 at 9:50 a.m. When asked how she	F 256	**4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. The Activity Coordinator / designee will report the responses of the residents to the QAPI committee monthly for 3 months. b. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	4/14/17 4/14/17

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reads her mail, Resident #2 stated, "I have to take it to the alcove outside the activity room to read it, there's not enough light in here (The residents room) to read it. We are getting older and our eyes need more light."

On 3/2/17 at 9:55 a.m. other staff member (OSM) #4, the director of maintenance, was asked if anyone had complained of there not being enough light in the resident rooms, OSM #4 stated, "I've always felt that there wasn't enough light in these rooms but yes, some residents complained and I put the newer spiral light bulbs that are equivalent to a 60 watt bulb in the bedside lamps." OSM #4 was taken to Resident #2's room. When asked if there was enough lighting, OSM #4 stated, "Yes, it's not bright in here." When shown the lamps on the bedside tables, OSM #4 stated, "We have to put those lamp shades back on, that's a fire hazard."

The above concern was shared with the administrator on 3/2/17 at 10:15 a.m. A policy was requested on resident room lighting and the administrator stated there was not a policy.

No further information was provided prior to exit.

1. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 544.
2. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 523.
3. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 420.
4. Barron's Dictionary of Medical Terms for the

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Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 435.

2. Resident #12 resided on the window side of the room and there was not adequate lighting to meet her needs.

Resident #12 was admitted to the facility on 10/6/16 with diagnoses that included but were not limited to: muscle weakness, high blood pressure, anxiety, atrial fibrillation (rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation) (1), and COPD (chronic obstructive pulmonary disease - chronic nonreversible lung disease) (2).

The most recent MDS (minimum data set), a significant change assessment, with an assessment reference date, of 1/13/17, coded the resident as being cognitively intact to make daily decisions, scoring a 15 on the BIMS (brief interview for mental status). In Section B1000 - Vision, the resident was coded as having the ability to see in adequate light. In Section B1200 - Corrective Lenses, the resident was coded as not having to use glasses, magnifying glass or contacts to complete Section B1000.

The comprehensive care plan dated 10/10/16 did not address vision.

On 3/1/17 at 2:30 p.m. Resident #12 was observed in her room. She resided on the side of the bed with the window. She was observed leaning across her bed with a piece of paper in her hands, reading it. When asked if there was

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enough light in the room for her to read her mail, Resident #12 stated, "No, I can barely read it leaning toward the window." (It was a bright sunny day outside). When asked why the lampshades were off of her night stand lamp, Resident #12 stated, "We took them off to add light but then they get too hot so we have to turn them off." When asked if she and her roommate (Resident #2) had told anyone of the concern about the lighting, Resident #12 stated, "We had told the nurses, can't remember who we (her and her roommate) told." When asked if they had told the administrator, Resident #12 stated, "We didn't tell the administrator because we didn't think it would make a difference." Resident #12 stated she had worked for an electrical contractor and there was not enough light in the room.

On 3/2/17 at 9:55 a.m. other staff member (OSM) #4, the director of maintenance, was asked if anyone had complained of there not being enough light in the resident rooms, OSM #4 stated, "I've always felt that there wasn't enough light in these rooms but yes, some residents complained and I put the newer spiral light bulbs that are equivalent to a 60 watt bulb in the bedside lamps." OSM #4 was taken to Resident #2's room. When asked if there was enough lighting, OSM #4 stated, "Yes, it's not bright in here." When shown the lamps on the bedside tables, OSM #4 stated, "We have to put those lamp shades back on, that's a fire hazard."

The above concern was shared with the administrator on 3/2/17 at 10:15 a.m. A policy was requested on resident room lighting and the administrator stated there was not a policy.

No further information was provided prior to exit.

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1. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55.
2. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
3. For Resident # 13 the facility staff did not provide adequate lighting in the Resident's room.

Resident # 13 was admitted to the facility on 11/22/10 with diagnoses that included but are not limited to: hypertension, hyperlipidemia, gastroesophageal reflex disease, diabetes, lymphedema (1), and diabetic retinopathy (2). On the most recent MDS (minimum data set), a quarterly assessment with ARD (assessment reference date) of 1/31/17, Resident # 13 was coded as scoring a 13 out of a possible 15 on the BIMS (brief interview of mental status) indicating that she was cognitively intact. Resident # 13 was coded under Vision as a "1" indicating that her vision was impaired and as wearing corrective lenses.

Review of Resident # 13 care plan revealed a documented care plan for a "Focus: (name of Resident # 13) has impaired vision, dx (diagnosis) diabetic retinopathy Date initiated: 06/02/2016"
"Interventions:
- Adapt environment to resident's individual needs to ensure resident is able to recognize objects/own environment
- Keep environment free of small objects and clutter
- Obtain eye exam consultation as needed
- Use large print materials with resident when needed

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F 256	Continued From page 13 - Utilize glasses per MD (medical doctor) orders." During the Group Interview Task on 3/1/17 at 10:30 a.m., Resident # 13 was present and when the group was asked if there was adequate light in their rooms Resident # 13 responded that the lighting could be better. During an interview and observation on 3/2/17 at 8:50 a.m. with Resident # 13, Resident # 13's room was observed and it was noted to have two overhead (ceiling) lights, one near the room door and one near the television, and a table lamp. There were no lights observed over the bed and if the bed curtains were pulled there were no lights inside the enclosure or above the bed. Resident # 13 stated that the room could be brighter and the resident noted there are two overhead lights and one table lamp. Resident # 13 further stated that the lack of light mostly bothers her at night because you cannot see to do anything. On 3/2/17 at 9:55 a.m. other staff member (OSM) #4, the director of maintenance, was asked if anyone had complained of there not being enough light in the resident rooms. OSM #4 stated, "I've always felt that there wasn't enough light in these rooms but yes, some residents complained and I put the newer spiral light bulbs that are equivalent to a 60 watt bulb in the bedside lamps." OSM #4 was taken to Resident #13's room, a private room. The night stand with the light was positioned on the left side of the bed. It was outside the confines of the privacy curtain. The privacy curtain was pulled. There was no light within the perimeter of the privacy curtain. When asked how the staff could see to provide care, OSM #4 stated, "I guess we can move the night stand to the other side of the bed."	F 256		

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OSM #4 was asked to first ask the resident if that is acceptable.

During an interview on 3/2/17 at 10:00 a.m. with ASM (administrative staff member) # 1, the administrator, and OSM (other staff member) # 4, the director of maintenance, this concern was discussed.

Nothing further provided prior to exit.

1. Lymphedema: is the name of a type of swelling. It happens when lymph builds up in your body's soft tissues. Lymph is a fluid that contains white blood cells that defend against germs. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=Lymphedema&commit=Search

2. Diabetic retinopathy: is caused by changes in the blood vessels of the retina. It is the most common diabetic eye disease and a leading cause of blindness in American adults. https://www.nei.nih.gov/faqs/diabetic-retinopathy

4. For Resident # 22 the facility staff did not provide adequate lighting in the Resident's room.

Resident # 22 was admitted to the facility on 5/4/10 and most recently readmitted on 4/14/14 with diagnoses that included but are not limited to: Atrial fibrillation, hypertension, anxiety, gastroesophageal reflex disease, diabetes, arthritis, depression, and bipolar disorder. On the most recent MDS (minimum data set), an annual assessment with ARD (assessment reference date) of 2/20/17, Resident # 22 was coded as scoring a 15 out of a possible 15 on the BIMS

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(brief interview of mental status) indicating that he was cognitively intact. Resident # 22 was coded under Vision as a "0" indicating that her vision was adequate and she was coded as wearing corrective lenses.

Review of Resident # 22's care plan revealed a documented care plan for a "Focus: Potential for impaired vision and/or complications Date initiated: 12/6/2016"
"Interventions:
- Adapt environment to resident's individual needs to ensure resident is able to recognize objects/own environment
- Instill/apply eye medication as per physician orders
- Keep environment free of small objects and clutter
- Obtain eye exam consultation as needed
- Teach/ensure resident turns head side to side when ambulating
- Use large print materials with resident when needed"

During the Group Interview Task on 3/1/17 at 10:30 a.m., Resident # 22 was present and when the group was asked if there was adequate light in their rooms Resident # 22 stated she had a problem with the lighting but her friend brought her two lamps and now it was fine.

During an interview and observation on 3/2/17 at 9:05 a.m. Resident # 22's room was observed to have two additional floor lamps that Resident # 22 identified as having been brought in by a friend and the table lamp that had been provided by the facility. Resident # 22 commented that the two floor lamps make the room much brighter.

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F 256	Continued From page 16 On 3/2/17 at 9:55 a.m. other staff member (OSM) #4, the director of maintenance, was asked if anyone had complained of there not being enough light in the resident rooms, OSM #4 stated, "I've always felt that there wasn't enough light in these rooms but yes, some residents complained and I put the newer spiral light bulbs that are equivalent to a 60 watt bulb in the bedside lamps." OSM #4 was taken to Resident #22's room. When shown the room, the resident had two pole lamps in the room in addition to the lamp on the night stand and the overhead lamp. OSM #4 was informed that the resident had a friend bring her the pole lamps because it was dark in her room. OSM #4 shook his head in agreement and stated, "I can see that." During an interview on 3/2/17 at 10:00 a.m. with ASM (administrative staff member) # 1, the administrator, and OSM (other staff member) # 4, the director of maintenance, this concern was discussed. Nothing further provided prior to exit.	F 256		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed.	F 278	**F 278** **SS=D** The facility will maintain an accurate MDS (minimum data set) assessment for each resident. **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #3's and #9's MDS was reviewed by the MDS coordinator and accurately reflects resident status as of 3/15/2017.	3/15/2017

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F 278	Continued From page 17 (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for two of 22 residents in the survey sample, Resident's #3 and #9. 1. The facility staff failed to accurately document the resident's weight and documented Resident #3 had had a weight loss when there had been no weights obtained on multiple MDS assessments. 2. The facility staff failed to accurately document the resident's height on the quarterly assessment with an assessment reference date (ARD) of	F 278	**2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. An audit of current resident's MDS assessments to ensure accuracy of height, weight, and weight losses will be completed by an RN MDS Coordinator to ensure current active assessment by 4/14/17. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. The Interdisciplinary Care Plan Team will be in-serviced by the RN MDS coordinator / designee on the appropriate use of "-" to answer sections of the MDS when there is no current information available for that resident and section of the MDS by 4/1/17. b. The Interdisciplinary Care Plan Team will meet weekly to review any residents with a significant weight change and document the interventions related to that Change in the Medical Record. **4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. The RN MDS coordinator /designee with the Dietary Services Manager / designee will audit 4 MDSs /week for 3 months to ensure the accuracy of section K. b. RN MDS coordinator / designee will report the results of audits to the QAPI committee monthly for 3 months. c. Audit results / trends will be reviewed by the QAPI committee to ensure that Action Plans are effective. Additional action plans will be done as needed.	4/14/17 4/1/17 4/14/17 4/14/17 4/14/17 4/14/17

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4/1/16 and a significant change assessment with an ARD of 4/19/17 for Resident #9.

The findings include:

1. The facility staff failed to accurately document the resident's weight and documented Resident #3 had had a weight loss when there had been no weights obtained on multiple MDS assessments.

Resident #3 was admitted to the facility on 4/22/10 with diagnoses that included but were not limited to: dementia, macular degeneration (Age-related macular degeneration (AMD) is a disease that blurs the sharp, central vision you need for "straight-ahead" activities such as reading, sewing, and driving. AMD affects the macula, the part of the eye that allows you to see fine detail) (1), a history of colon and breast cancer, and high blood pressure. The resident was currently under hospice care since 5/13/16.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD of 2/10/17, coded the resident as being severely impaired to make cognitive daily decisions. The resident was coded as being totally dependent on the staff for all of her activities of daily living.

Review of the clinical record documented the last obtained weight was on 5/9/16. The resident's weight was 149.4 pounds.

The significant change MDS assessment, with an ARD 5/20/16 in Section K - Swallowing/Nutritional Status coded the resident with a weight "000." A "2" was documented in the column for "Loss of 5% or more in the last month or loss of 10% or

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more in last 6 months, indicating the resident was not on a physician-prescribed weight- loss regimen.

The quarterly MDS assessment, with an ARD of 8/19/16, coded the resident in Section K - Swallowing/Nutritional Status, as having a weight of "000." A "2" was documented in the column for "Loss of 5% or more in the last month or loss of 10% or more in last 6 months, indicating the resident was not on a physician-prescribed weight- loss regimen.

The quarterly MDS assessment, with an ARD of 11/14/16, coded the resident in Section K - Swallowing/Nutritional Status, as having a weight of "000." A "2" was documented in the column for "Loss of 5% or more in the last month or loss of 10% or more in last 6 months, indicating the resident was not on a physician-prescribed weight- loss regimen.

The quarterly MDS assessment, with an ARD of 2/10/17, coded the resident in Section K - Swallowing/Nutritional Status, as having a weight of "000." A "2" was documented in the column for "Loss of 5% or more in the last month or loss of 10% or more in last 6 months, indicating the resident was not on a physician-prescribed weight- loss regimen.

An interview was conducted with RN (registered nurse) #3, the MDS coordinator, on 3/1/17 at 11:52 a.m. When asked who completes Section K, RN #3 stated, "It's either the dietician or the dietary manager." When asked how that is coded on the MDS, if the resident has not had a weight obtained, RN #3 stated, "I believe it should be dashes put in there." RN #3 was asked which

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manual the facility uses to complete the MDS assessments, RN #3 stated, "We use the RAI (resident assessment instrument) manual." RN #3 was asked to bring a copy of completing Section K regarding weight documentation.

On 3/1/17 at 12:10 p.m. RN #3 presented a copy from the RAI manual. The paper documented in part, "If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale in the resident's medical record." The RAI manual further documented, "For Subsequent Assessments: 37. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago. 38. If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss. 39. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 180 days ago. 40. If the current weight is less than the weight in the observation period 180 days ago, calculate the percentage of weight loss."

An interview was conducted with other staff member (OSM) #1, the dietary manager, on 3/1/17 at 1:05 p.m. When asked why she coded the resident on the MDS assessments, with triple zeros, OSM #1 stated, "The zeros should be dashes. I didn't know that until today." When asked how you can code a resident with a weight loss when there has not been any weights taken since May of 2016, OSM #1 stated, "I guess that's an error."

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The administrators, director of nursing and corporate nurse were made aware of the above findings on 3/1/17 at 4:37 p.m.

No further information was provided prior to exit.

1. This information was obtained from the following website: https://nei.nih.gov/health/maculardegen/

2. The facility staff failed to accurately document the resident's height on the quarterly assessment with an assessment reference date (ARD) of 4/1/16 and a significant change assessment with an ARD of 4/19/16 for Resident #9.

Resident #9 was admitted to the facility on 12/6/10 with a recent readmission on 9/3/16 with diagnoses that included but were not limited to: diabetes, high blood pressure, stroke, osteoarthritis, lymphoma (cancer of the lymph system) (1), and anemia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/9/16 coded the resident as being severely impaired to make daily decisions. The resident was coded as being totally dependent upon the staff for all of her activities of daily living.

The quarterly MDS assessment with an ARD of 4/1/16, coded the resident in Section K - Swallowing/Nutritional Status, as being 50 inches tall. The MDS documented, "A. Height (in inches). Record most recent height measure since the most recent admission/entry or reentry."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYLER'S RETREAT AT IRON BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831

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The significant change MDS assessment with and ARD of 4/19/16 coded the resident in Section K -Swallowing/Nutritional Status, as being 50 inches tall.

The Medicare five day MDS assessment with an ARD of 5/9/16 coded the resident in Section K - Swallowing/Nutritional Status, as being 60 inches tall.

The Medicare 14 day MDS assessment with an ARD of 5/16/16, coded the resident in Section K - Swallowing/Nutritional Status, as being 60 inches tall.

An interview was conducted on 3/1/17 at 11:42 a.m. with RN (registered nurse) #2, the MDS coordinator. When asked who documents the height on the MDS assessments, RN #2 stated, "The dietary manager or the dietician." RN #2 was informed of the height difference on the above MDS assessments. She stated she'd look into it and get back with this surveyor.

An interview was conducted on 3/1/17 at 1:07 p.m. with other staff member (OSM) #1, the dietary manager. When asked who enters the height into the computer for the MDS assessments, OSM #1 stated, "Nursing enters the heights." When asked to explain the two different heights on the above MDS assessments, OSM #1 stated, "The 50 inches was taken with the resident lying down. When we transferred to (name of computer system) it probably got entered wrong, it should be five foot."

On 3/1/17 at 3:14 p.m. OSM #1 stated, "I spoke to the dietician and she said she changed the

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F 278	Continued From page 23 height to 60 inches as she knew 50 inches wasn't correct. The resident is five foot tall or 60 inches." The administrator, director of nursing and ASM (administrative staff member) #3, the corporate nurse, were made aware of the above findings on 3/1/17 at 4:37 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman; Page 346.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 279	**F279** **SS=D** The facility will develop care plans for the CAA (care area assessment) triggered areas of the MDS. **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #1's care plan was reviewed by the IDCP team and updated to include care plans on delirium and cognition. b. Resident #10's care plan was reviewed by the IDCP team and updated to include a pressure ulcer prevention care plan. **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents with comprehensive assessments in past 30 days will be reviewed by members of the Inter Disciplinary Care Plan (IDCP) team to ensure triggered CAAs were addressed with coordinating care plans.	3/31/17 3/31/17 3/31/17

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F 279	Continued From page 24 (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document	F 279	b. Any triggered CAA's that were not addressed on the Care Plan will reported to the RN MDS coordinators for review and correction by the Care Plan Team. 4/7/17 **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. The IDCP team will be in-serviced on updating /creating care plans related to MDS CAA triggers by RN MDS coordinator / designee. 4/1/17 **4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. IDCP team to audit 4 comprehensive assessments per week for 3 months to ensure Care Plans are appropriate. 4/14/17 b. Social Services / designee will report the results of audits to the QAPI committee monthly for 3 months. 4/14/17 c. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed. 4/14/17	

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review, and clinical record review, it was determined that facility staff failed to develop a comprehensive care plan for two of 22 residents in the survey sample, Resident # 1, and # 10.

1. The facility staff failed to develop a care plan for the CAA (care area assessment) triggered areas of delirium and cognition in Section V of Resident #1's significant change MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/30/16.

2. The facility staff failed to develop a care plan for the CAA (care area assessment) triggered area of pressure ulcer in Section V of Resident #10's annual MDS assessment with an ARD of 04/04/16.

The findings include:

1. Resident # 1 was admitted to the facility on 02/07/13 with a readmission on 11/23/16 with diagnoses that included but not limited to: spinal stenosis (1), hypertension (2), rheumatoid arthritis (3), joint pain, muscle weakness, depression, osteoporosis (4), and gastroesophageal reflux disease (5).

The most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 11/30/16 coded the resident as scoring a seven on the brief interview for mental status (BIMS) of a score of 0 - 15, seven being severely impaired of cognition. Resident # 1 was coded as requiring extensive assistance of one staff member for activities of daily living. Review of Section V Care Area Assessment (CAA) Summary revealed, "01 Delirium" and "02. Cognition" was coded as

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F 279	Continued From page 26 "Addressed in Care Plan." Review of Resident # 1's comprehensive care plan with dated of 01/16/2016 failed to evidence a care plan to address Resident # 1's delirium and cognition. On 02/28/17 at 3:35 p.m., an interview was conducted with OSM (other staff member) # 3, the social worker. When asked about the assessment for delirium and cognition on Resident # 1's significant change assessment with the ARD of 11/30/16, OSM # 3 stated, "I did the assessment for delirium and cognition." After reviewing the care plan dated 01/16/2016 for Resident # 1, OSM # 3 was asked if a care plan was developed for delirium and cognition. OSM # 3 stated, "I determined that the delirium and cognition was more depression and there was already a care plan for depression. Looking back there should have been care plans developed for delirium and cognition." On 02/28/17 at 3:40 p.m., an interview was conducted with RN (registered nurse) # 2, MDS coordinator regarding the CAA area of delirium and cognition being identified for a care plan. When asked about the process of developing a care plan from the triggered areas on the CAA of an MDS assessment, RN # 2 stated, "If the area triggered on the CAA a care plan should be developed according to the RAI (resident assessment instrument)." After reviewing the significant change MDS assessment with the ARD of 11/30/16 for Resident # 1 and the comprehensive care plan dated of 01/16/2016, RN # 2 stated, "It's not on the care plan. A care plan should have been developed."	F 279		

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The facility's policy "Care Plan" documented, "F. The Comprehensive Care Plan is reviewed and updated at least every 90 days by the interdisciplinary team."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

On 03/01/17 at approximately 4:40 p.m. the ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing and ASM # 3, corporate consultant, were made aware of the findings.

No further information was provided prior to exit.

References:

(1) A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm.

(2) High blood pressure. This information was

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obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(3) A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.

(4) Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

(5) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

2. Resident # 10 was admitted to the facility on 04/04/13 with a readmission on 03/30/15 with diagnoses that included but not limited to: diabetes mellitus (1), cerebral vascular accident (2), bilateral (right and left sides) deep vein thrombosis (3), hypertension (4), gastroesophageal reflux disease (5), epilepsy (6), anxiety (7), edema (8), neuropathy (9), glaucoma (10), and pain.

The most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 04/04/16 coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact for daily decision making. Resident # 10 was coded as requiring extensive

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assistance of one staff member for activities of daily living. Review of Section V Care Area Assessment (CAA) Summary revealed, "16. Pressure Ulcer" was coded as "Addressed in Care Plan."

Review of Resident # 10's comprehensive care plan dated 04/04/2016 failed to evidence a care plan to address pressure ulcer.

On 02/28/17 at 3:40 p.m., an interview was conducted with RN (registered nurse) # 2, MDS coordinator regarding the triggered CAA area of pressure ulcer being identified for a care plan. When asked about the process of developing a care plan from the triggered areas on the CAA of an MDS assessment, RN # 2 stated, "If the area triggered on the CAA a care plan should be developed according to the RAI (resident assessment instrument)." After reviewing the annual MDS assessment with the ARD of 04/04/16 for Resident # 10 and the comprehensive care plan dated of 04/04/2016, RN # 2 stated, "Only a portion of the pressure ulcer care plan was resolved, there should be a care plan for pressure ulcer. The entire pressure ulcer care plan was resolved accidently. There still should be a care plan for pressure ulcer."

On 03/01/17 at approximately 4:40 p.m. the ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing and ASM # 3, corporate consultant, were made aware of the findings.

No further information was provided prior to exit.

References:

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(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(2) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

(3) A condition that occurs when a blood clot forms in a vein deep inside a part of the body. It mainly affects the large veins in the lower leg and thigh, but can occur in other deep veins such as in the arms and pelvis. This information was obtained from the website: https://medlineplus.gov/ency/article/000156.htm.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(6) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms

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F 279	Continued From page 31 or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html. (7) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (8) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. (9) Peripheral neuropathy means these nerves don't work properly. Peripheral neuropathy may occur because of damage to a single nerve or a group of nerves. It may also affect nerves in the whole body. This information was obtained from the website: https://medlineplus.gov/ency/article/000593.htm. (10) A group of diseases that can damage the eye's optic nerve. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/glaucoma.html.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to	F 280	**F280** **SS=D** The facility will review and revise the resident comprehensive care plans. **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #10 order for splint was evaluate by Occupational Therapist on 3/2/17. The occupational Therapist determined that the splints were no longer warranted as they were originally prescribed due to the resident's fingers tingling and that she no longer was experiencing the tingling. The resident's care plan was updated by the IDCP Team to reflect these changes.	3/3/17

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F 280	Continued From page 32 request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 280	**2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. Residents with a splint(s) have the potential to be affected by this deficient practice. 4/14/17 b. Current residents with splint orders will have their care plan reviewed for accuracy and completeness by the IDCP team. 3/31/17 **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. The IDCP team will be in-serviced on developing and updating care plans with new MD Orders and changes in condition by the RN MDS coordinator / designee. 4/1/17 b. Residents with significant changes will be reviewed weekly by the IDCP team and their care plans updated to reflect changes, goals and interventions. 4/14/17 **4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. The IDCP team will audit 4 Care Plans per week weekly for 3 months for accuracy and completeness. 4/14/17 b. Social Services / designee will report the results of audits to the QAPI committee monthly for 3 months. 4/14/17 c. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed. 4/14/17	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495401	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYLER'S RETREAT AT IRON BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831

(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) COMPLETIOI DATE
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request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

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F 280	Continued From page 33 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined that the facility staff failed to review and revise the comprehensive care plan for one of 22 residents in the survey sample, Resident # 10. The facility staff failed to revise the comprehensive care plan for the use of a splint	F 280		

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for Resident 10's left hand.

The findings include:

Resident # 10 was admitted to the facility on 04/04/13 with a readmission on 03/30/15 with diagnoses that included but not limited to: diabetes mellitus (1), cerebral vascular accident (2), bilateral (right and left sides) deep vein thrombosis (3), hypertension (4), gastroesophageal reflux disease (5), epilepsy (6), anxiety (7), edema (8), neuropathy (9), glaucoma (10), and pain.

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/16/16 coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact for daily decision making. Resident # 10 was coded as requiring extensive assistance of one staff member for activities of daily living. Resident # 10 was coded as having impairment of range of motion of the upper extremity (shoulder, elbow, wrist, hand) on one side.

The physician's "Telephone Order" for Resident # 10 dated 11/28/16 documented, "Pt (patient) to wear (L)UE [left upper extremity] splint X6 (six hours) daily during the day."

The POS (physician's order sheet) dated 03/01/17 through 03/31/17 documented, "11/28/16: Wear left UE (upper extremity) splint X 6 hours daily during the day."

The TARs (treatment administration records) dated 01/01/2017 - 01/31/2017, 02/01/2017 -

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02/28/2017 and 03/01/2017 - 03/30/2017 documented, ""11/28/16: Wear left UE (upper extremity) splint X 6 hours daily during the day."

Review of Resident # 10's comprehensive care plan dated 04/04/2016 failed to evidence documentation for the use of a left upper extremity splint.

On 03/02/17 at 9:30 a.m. an interview was conducted with RN (registered nurse) # 6, the unit manager and ASM (administrative staff member) # 2, the director of nursing. RN # 6 and ASM # 2 were asked to review the physician's orders dated 03/01/17 through 03/31/17 and the care plan dated 04/04/2016 for Resident # 10. When asked if the care plan was revised to reflect the use of a left hand splint for Resident # 10, RN # 6 and ASM # 2 stated, "It's not there. It should have been revised to indicate the use of the left hand splint."

The facility policy "Care plans" documented, "The facility must develop a comprehensive Care Plan for each resident that includes measurable objectives to meet the resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment."

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

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revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

On 03/01/17 at approximately 4:40 p.m. the ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing and ASM # 3, corporate consultant, were made aware of the findings.

No further information was provided prior to exit.

References:

(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(2) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

(3) A condition that occurs when a blood clot forms in a vein deep inside a part of the body. It mainly affects the large veins in the lower leg and thigh, but can occur in other deep veins such as in the arms and pelvis. This information was obtained from the website: https://medlineplus.gov/ency/article/000156.htm.

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(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(6) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

(7) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(8) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html.

(9) Peripheral neuropathy means these nerves don't work properly. Peripheral neuropathy may occur because of damage to a single nerve or a group of nerves. It may also affect nerves in the whole body. This information was obtained from the website: https://medlineplus.gov/ency/article/000593.htm.

(10) A group of diseases that can damage the

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F 280	Continued From page 38 eye's optic nerve. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/glaucoma.html. (11) Paralysis is the loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, it was determined that facility staff failed to follow professional standards of practice for one of two medication rooms, the 300/400 unit's medication room. Facility staff failed to label a lidocaine (1) multidose vial when opened. The findings include: An observation was made on 3/1/17 at 2:55 p.m. of the medication room on the 300/400 units with RN (registered nurse) #7. Upon entering the medication room a multidose vial of 20 milliliter bottle of lidocaine was lying in plastic container on the shelf. The vial had been opened but there	F 281	**F 281** **SS=D** The facility will ensure staff follows professional standards of practice. **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were found to be affected by deficient practice. **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents receiving a lidocaine injection have the potential to be affected. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. Staff will be in-serviced on storage of medications policy / procedure by DON/designee by 4/1/17.	4/14/17 4/1/17

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F 281	Continued From page 39 was no open date documented on the label. The vial was approximately one-half full. An interview was conducted on 3/1/17 at 2:56 p.m. with RN #7. When asked to look at the multidose vial of lidocaine, RN #7 stated, "It's not labeled with the open date." When asked how staff would know when the multidose vial of lidocaine expired, RN #7 stated, "I don't know when it was opened." An interview was conducted on 3/1/17 at 4:45 p.m. with ASM (administrative staff member) #2, the director of nursing regarding the process staff followed when they opened a multidose vial of medication. ASM #2 stated, "We date it." ASM #2 was asked when the multidose vial of lidocaine observed in the medication room on the 300/400 unit would expire. ASM #2 stated she didn't know. ASM #2 was asked when the multi-dose vial of lidocaine should be discarded. ASM #2 stated, "It depends on when it expires." When asked what nursing standard the staff used, ASM #2 stated, "We use Lippincott and our policies." A request for the lidocaine manufacturer's literature was made at this time and ASM #2 was made aware of the findings. Review of the lidocaine multidose vial manufacturer's literature did not specify how long after a vial was opened before it was expired. A telephone interview was conducted on 3/2/17 at 10:35 a.m. with OSM (other staff member) #5, the pharmacist. OSM #5 was asked when a multidose vial of lidocaine expired after opening. OSM #5 stated, "It's good for 28 days after it's opened." When asked what source the pharmacy used, OSM #5 stated, "(Name of pharmacy) form	F 281	**4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. RN Unit Manager/ designee will audit Medication rooms weekly for 1 month, monthly for 2 months to ensure multi-dose vials are dated when opened. b. RN Unit Manager/designee will report the results of audits to the QAPI committee monthly for 3 months. c. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	4/14/17 4/14/17 4/14/17

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F 281	Continued From page 40 we have." Review of the pharmacy's document titled, "Recommended Minimum Storage Parameters (based on manufacturer's guidelines)." documented, "Multiple-Dose Vials for Injection. Date when opened and discard unused portion after 28 days or in accordance with manufacturer's recommendations." Review of the facility's policy titled, "General Dose Preparation and Medication Administration" documented, "Procedure: 3.11 Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins, irrigation solutions, etc.)." No further information was provided prior to exit. In addition, the United States Pharmacopeia (USP) General Chapter 797 [16] recommends the following for multi-dose vials of sterile pharmaceuticals: If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. This information was obtained from the website: http://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html (1) lidocaine -- Lidocaine is a local anesthetic and cardiac depressant used as an antiarrhythmia agent. Its actions are more intense and its effects more prolonged than those of PROCAINE but its duration of action is shorter than that of BUPIVACAINE or PRILOCAINE. This information was obtained from the following website: https://pubchem.ncbi.nlm.nih.gov/compound/lidocaine	F 281		

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F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain the highest level of well-being for one of 22 residents in the survey sample, Resident #10. The facility staff failed to apply Resident # 10's right hand splint according the physician's orders.	F 309	**F 309** **SS=D** The facility will ensure that each resident received 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. **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #10 order for splint was evaluate by Occupational Therapist on 3/2/17. The occupational Therapist determined that the splints were no longer warranted as they were originally prescribed due to the resident's fingers tingling and that she no longer was experiencing the tingling. MD informed of findings and wrote an order for splints to be discontinued. **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. A splint audit will be conducted for residents identified with orders for splints by the RN Unit Managers. b. Resident's found with a splint order that is not being followed or is confusing as to the time the splint is to be worn will be referred to Therapy for evaluation and / or clarification. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. Licensed Nurses will be in-serviced on following physician orders by Director of Nursing / designee by 4/1/17.	3/2/17 3/31/17 3/31/17 4/1/17

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F 309	Continued From page 42 The findings include: The facility staff failed to apply Resident # 10's right hand splint according the physician's orders. Resident # 10 was admitted to the facility on 04/04/13 with a readmission on 03/30/15 with diagnoses that included but not limited to: diabetes mellitus (1), cerebral vascular accident (2), bilateral (right and left sides) deep vein thrombosis (3), hypertension (4), gastroesophageal reflux disease (5), epilepsy (6), anxiety (7), edema (8), neuropathy (9), glaucoma (10), and pain. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/16/16 coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact for daily decision making. Resident # 10 was coded as requiring extensive assistance of one staff member for activities of daily living. Resident # 10 was coded as having impairment of range of motion of the upper extremity (shoulder, elbow, wrist, hand) on one side. On 02/28/17 at 2:00 p.m. Resident # 10 was observed lying in her bed watching television. Further observations of Resident # 10 failed to evidence a splint on her right hand. On 02/28/17 at 4:05 p.m. Resident # 10 was observed sitting in her wheelchair outside her room in the hallway. Further observations of Resident # 10 failed to evidence a splint on her right hand.	F 309	**4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. RN Unit Manager / designee will audit residents with splints weekly for 3 months to ensure splints are on as ordered by physician. b. RN Unit Manager / designee will report the results of audits to the QAPI committee monthly for 3 months. c. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	4/14/17 4/14/17 4/14/17

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On 03/01/17 at 11:05 a.m. Resident # 10 was observed sitting up in her bed watching television. Further observations of Resident # 10 failed to evidence a splint on her right hand.

On 03/01/17 at 3:00 p.m. Resident # 10 was observed in the dining room sitting up in her wheelchair participating in BINGO with numerous other residents. Further observations of Resident # 10 failed to evidence a splint on her right hand.

On 03/02/17 at 8:45 a.m. Resident # 10 was observed sitting up in her bed watching television and eating breakfast independently. Further observations of Resident # 10 failed to evidence a splint on her right hand.

The POS (physician's order sheet) dated 03/01/15 through 03/31/15 documented, "Apply splint to (R) hand in the morning and remove at H.S. (at bedtime)."

Review of Resident # 10's comprehensive care plan dated 04/04/2016 documented, "Focus: Self-care deficit r/t [related to] (L) [left] CVA [cerebral vascular accident] with ® [right] sided hemiparesis (11)." Under "Interventions" it documented, "(R) hand splint as ordered."

The TARs (treatment administration records) dated 01/01/2017 - 01/31/2017, 02/01/2017 - 02/28/2017 and 03/01/2017 - 03/30/2017 documented, "Splint to right hand in the morning and remove at bedtime. 7-3 (7:00 a.m. to 3:00 p.m.) On. 3-11(3:00 p.m. to 11:00 p.m.) Off." Further review of the TARs dated 01/01/2017 - 01/31/2017, 02/01/2017 - 02/28/2017 and 03/01/2017 - 03/30/2017 revealed documentation

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indicating the splint to Resident # 10's right hand was being applied each morning and removed at bed time.

On 03/01/17 at 3:30 p.m. an interview was conducted with Resident # 10. When asked if she has the splint for her right hand Resident # 10 stated, "Yes, It's on the table by my bed." An immediate observation of Resident # 10 bedside table revealed a hand splint for Resident # 10's right hand. Resident #10 was asked when the splint for her right hand is applied. Resident # 10 stated, "They put the splint on my right hand at night and take it off in the morning." When asked who puts the splint on her hand, Resident # 10 stated, "The CNAs (certified nursing assistants)."

On 03/02/17 at 11:30 a.m. an interview was conducted with CNA # 7 regarding the wearing schedule of Resident # 10's right hand splint. When asked if she had taken care of Resident # 10, CNA # 7 stated, "I'm assigned to her." When asked if Resident # 10 wore a splint on her right hand and when it was applied, CNA # 7 stated, "It's supposed to be put on in the morning and taken off at bedtime." When asked who put the splint on Resident # 10's right hand CNA # 7 stated, "The CNAs put it on."

On 03/02/17 at 12:00 p.m. an interview was conducted with LPN (licensed practical nurse) # 8. When asked if Resident # 10 wore a splint on her right hand and when it was applied, LPN # 8 stated, "It's put on in the morning and taken off at bedtime." When asked who put the splint on Resident # 10's right hand, LPN # 8 stated, "The aides."

On 03/02/17 at 12:10 p.m. an interview was

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conducted with RN (registered nurse) # 6, the unit manager, regarding the wearing schedule of Resident # 10's right hand splint. When asked if Resident # 10 wore a splint on her right hand and when it was applied, RN # 6 stated, "It's supposed to be put on in the morning and taken off at bedtime." When asked who put the splint on Resident # 10's right hand, RN # 6 stated, "The nurse should be putting on the splint because they are ones that have to document it." When asked if she was aware that the splint was being put on Resident # 10 at night, RN # 6 stated, "No."

On 03/02/17 at 12:10 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked who should apply the splint on Resident # 10's right hand, ASM # 2 stated, "Both the nurse and CNA but the nurse would need the check it and then document it. When asked if she was aware that the splint was being put on Resident # 10 at night, ASM #2 stated, "No."

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

On 03/02/17 at approximately 12:40 p.m. the ASM (administrative staff member) # 1, the administrator, and ASM # 3, corporate consultant, were made aware of the findings.

No further information was provided prior to exit.

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References:

(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(2) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

(3) A condition that occurs when a blood clot forms in a vein deep inside a part of the body. It mainly affects the large veins in the lower leg and thigh, but can occur in other deep veins such as in the arms and pelvis. This information was obtained from the website: https://medlineplus.gov/ency/article/000156.htm.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(6) A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have

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F 309	Continued From page 47 strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html. (7) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (8) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html. (9) Peripheral neuropathy means these nerves don't work properly. Peripheral neuropathy may occur because of damage to a single nerve or a group of nerves. It may also affect nerves in the whole body. This information was obtained from the website: https://medlineplus.gov/ency/article/000593.htm. (10) A group of diseases that can damage the eye's optic nerve. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/glaucoma.html. (11) Paralysis is the loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html.	F 309		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or	F 371	**F 371** **SS=D** The facility will store food in a safe and sanitary manner.	

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F 371	Continued From page 48 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 observation, staff interview and facility document review, it was determined that the facility staff failed to store food in a sanitary manner. A twenty-five pound box of powder thickener was found stored open to the air. The findings include: Observation of the kitchen was conducted on 02/28/17 at approximately 11:30 a.m. The following was observed:	F 371	**1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were found to have been affected. **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** Residents on pureed diets have the potential to be affected. 4/14/17 **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. Thicken Powder will be stored in a container with a lid which will seal tightly when closed. A label will be placed on the container with the product name and date the product was put into the container. 3/15/17 b. Dietary staff will be in-serviced by the Dietary Services Manager on the policy and procedure of storing food products. 3/31/17 c. The cook will check the store room daily and document on a store room check sheet that all containers are closed appropriately. 3/31/17 **4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. The Dietary Services Manager will spot check the store room and check sheet at least weekly and will report the results of the audits to the QAPI committee for 3 months. 4/14/17 b. Audit results / trends will be reviewed at the QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed. 4/14/17	

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F 371	Continued From page 49 A twenty-five pound box of powered thickener with approximately fourteen pounds left in the box was observed opened to the air on the bottom storage shelf in the dry storage room. On 02/28/17 at approximately 12:45 p.m. the above concerns were shown to OSM (other staff member) #1, a dietary manager. OSM #1 stated that the powdered thickener should have been sealed and closed. The facility policy "Storing Dry Food" documented in part, "Storage of bulk items ... Packaged items (i.e. bulk cereal) must be stored in a container or sealed tightly to avoid insect infestation." On 03/01/17 at approximately 4:40 p.m. the ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing and ASM # 3, corporate consultant, were made aware of the findings. No further information was provided prior to exit.	F 371		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 514	**F 514** **SS=D** The facility will ensure that clinical records are maintained on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #4 and 7's medications have been documented in the clinical record by licensed nurses since 3/19/17. b. Resident # 9 had the incorrect form removed from her medical record on 3-1-17.	3/19/17 3/1/17

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F 514	Continued From page 50 (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documents review and clinical record review, it was determined that facility staff failed to maintain a complete and accurate clinical record for three of 22 resident in the survey sample, Resident #7, Resident #4 and Resident #9. 1. The facility staff failed to document that Resident #7 received levothyroxine (thyroid medication (1)) as ordered by the physician on the medication administration record (MAR) on four dates in December 2016 and two dates in January 2017. 2. The facility staff failed to document that Resident #4 received estrace cream (hormone	F 514	**2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents have the potential to be affected. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. Staff will be in-serviced on medication administration policy by DON/designee by 4/1/17. b. Department Managers, Nurse Managers and Medical Records staff will be in-serviced on HIPPA policy by Administrator / designee by 3/31/17 **4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. Medical Records / designee will audit 4 Medical Records per week for 3 months to ensure no reports are misfiled and will report the results of audits to the QAPI committee monthly for 3 months. b. RN Unit Manager/designee will audit 10 resident MAR's and TAR's per week for 4 weeks and 10 per month for 2 months to ensure complete and accurate documentation. c. Unit Manager / designee will observe 4 Medication passes per month to ensure medications are given and documented per MD order. d. RN Unit Managers / designee will report the results of their records audit and Medication Pass observations to the QAPI committee monthly for 3 months. e. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	4/14/17 4/1/17 3/31/17 4/14/17 4/14/17 4/14/17 4/14/17 4/14/17

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cream 2) as ordered by the physician on the December 2016 MAR.

3. The facility staff had filed another resident's information in Resident #9's clinical record.

The findings include:

1. The facility staff failed to document that Resident #7 received levothyroxine (thyroid medication (1)) as ordered by the physician on the medication administration record (MAR) on four dates in December 2016 and two dates in January 2017.

Resident #7 was admitted to the facility on 3/5/14 and readmitted on 1/25/17 with diagnoses that included but were not limited to: arthritis, fractured leg, dementia, high blood pressure and elevated cholesterol.

The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 2/8/17 coded the resident as having scored an 11 out of 15 on the brief interview for mental status indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident was coded as able to do after the meal tray was prepared.

Review of the physician's orders dated 1/31/17 documented, "Levothyroxine 75 mcg (micrograms) i (one) po (by mouth) every other day. Levothyroxine 50 mcg I po qod (every other day). 3/05/14."

Review of the December 2016 MAR documented,

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"LEVOTHYROXINE 75 MCG TABLET...1 TAB (tablet) BY MOUTH EVERY OTHER DAY... (ALTERNATING WITH 75 MCG). LEVOTHYROXINE 50 MCG TABLET...1 TAB BY MOUTH EVERY OTHER DAY...(ALTERNATING WITH 75 MCG). 3/05/14." On 12/12/16, 12/21/16, 12/29/16 and 12/31/16 there was no documentation that the medication had been administered.

Review of the January 2017 MAR documented, "LEVOTHYROXINE 75 MCG TABLET...1 TAB (tablet) BY MOUTH EVERY OTHER DAY... (ALTERNATING WITH 75 MCG). LEVOTHYROXINE 50 MCG TABLET...1 TAB BY MOUTH EVERY OTHER DAY...(ALTERNATING WITH 75 MCG). 3/05/14." on 1/6/17 and 1/17/17 there was no documentation that the medication had been administered.

On 3/1/17 at 4:45 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

A telephone interview was conducted on 3/2/17 at 12:11 p.m. with LPN #3, the nurse who did not document that the medication was given in December 2016 and on 1/6/17. When asked the process staff follow to document medications, LPN #3 stated, "When I come back (from giving the medication) I sign the MAR that I gave it." When the undocumented doses of levothyroxine were reviewed, LPN #3 stated, "I don't remember why I didn't do it..."

A telephone interview was conducted on 3/2/17 at 12:55 p.m. with LPN #6, the nurse who did not document that the medication was given. When

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asked if she cared for Resident #7, LPN #6 stated yes she had. When asked about the dates she had not documented that the medication had been given to the resident, LPN #6 stated, "I more than likely gave it. It might have been an oversight in singing." When asked why medications were documented, LPN #6 stated, "So I know they have been given."

An interview was conducted on 3/2/17 at approximately 1:10 p.m. with ASM #2, the director of nursing and the above staff interviews were shared. ASM #2 reviewed the December 2016 MAR which revealed documentation that LPN #3 had documented she had administered the medication on dates adjacent to the dates with the missing documentation. ASM #2 stated that the nurse most likely administered the medications but failed to document the medication was given.

Review of the facility's policy titled, "General Dose Preparation and Medication Administration documented,
"Procedure: 6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given....)."

No further information was provided prior to exit.

Lippincott, Williams and Wilkins, Fundamentals of Nursing, 2007, Ambler, PA, page 181 reads "Nurses carry a great deal of responsibility for making sure that patients get the right drugs at the right time, in the right dose and by the right

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routes ...this includes accurate documentation and explanation ..." Page 165 reads, "After administering a tablet or capsule, be sure to record: drug given, dose given, date and time of administration, signing out the drug on the patients medication record ..."

(1) Levothyroxine -- Levothyroxine sodium is used for the following indications: Hypothyroidism - As replacement or supplemental therapy in congenital or acquired hypothyroidism of any etiology, except transient hypothyroidism during the recovery phase of subacute thyroiditis. Specific indications include: primary (thyroidal), secondary (pituitary), and tertiary (hypothalamic) hypothyroidism and subclinical hypothyroidism. Primary hypothyroidism may result from functional deficiency, primary atrophy, partial or total congenital absence of the thyroid gland, or from the effects of surgery, radiation, or drugs, with or without the presence of goiter. This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=99AEBC74-0E34-4AB3-BB59-D9FB2B9A4444

2. The facility staff failed to document that Resident #4 received estrace cream (hormone cream (2)) as ordered by the physician on the December 2016 MAR.

Resident #4 was admitted to the facility on 5/31/13 and readmitted on 8/10/16 with diagnoses that included but were not limited to: depression, lung disease, high blood pressure and diabetes.

The most recent MDS, a quarterly assessment,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495401	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYLER'S RETREAT AT IRON BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831

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with an ARD of 1/13/17 coded the resident as having 13 out of 15 on the BIMS (brief interview for mental status) indicating that the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of Resident #4's care plan initiated on 3/21/16 and resolved on 12/20/16 documented, "Focus Risk for infection R/T (related to) chronic UTIs (urinary tract infections) and CKD (chronic kidney disease). Interventions medications as ordered."

Review of the physician's orders dated 1/2/17 documented, "ESTRACE (1) 0.01% CREAM/APPL (application) APPLY AS DIRECTED VAGINALLY TWO TIMES A WEEK 08/10/16."

Review of the December 2016 MAR documented, "ESTRACE 0.01% CREAM/APPL (application) APPLY AS DIRECTED VAGINALLY TWO TIMES A WEEK 08/10/16. FOR RECURRENT URINARY TRACT INFECTIONS." The MAR did not evidence documentation that the Estrace had been administered on 12/6/16, 12/9/16, 12/13/16 and 12/23/16.

Review of the December 2016 nurses' notes did not evidence documentation regarding the estrace as being administered.

A telephone interview was conducted on 3/2/17 at 10:28 a.m. with LPN #4, the nurse who cared for the resident on 12/6/16. When asked about the process followed by staff after administering a medication, LPN #4 stated they sign it off on the MAR. When asked why staff documents the

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	495401	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYLER'S RETREAT AT IRON BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831

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medication, LPN #4 stated "It is important. If I hadn't signed it, it could mean I didn't give it." When asked about giving Resident #4 the estrace on 12/6/16, LPN #4 stated, "I gave it to her but I didn't sign it off. Sometimes it's so dark at night I can't see to sign it."

A telephone interview was conducted on 3/2/17 at 12:06 p.m. with LPN #7, the nurse who cared for the resident on 12/9/16, 12/13/16 and 12/23/16. When asked about the process staff follows after they administer a medication, LPN #7 stated, "We sign it off." When asked why medication was documented, LPN #7 stated, "Otherwise if you don't document it don't know if it was given." The missing documentation for 12/9/16, 12/13/16 and 12/23/16 was then reviewed with LPN#7. LPN #7 stated, "I remember giving it. I had to have (name of aide) in there with me."

No further information was provided prior to exit.

(1) Estrace -- treats hot flashes and other symptoms related to menopause or low estrogen. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010183/?report=details

3. The facility staff had filed another resident's information in Resident #9's clinical record.

Resident #9 was admitted to the facility on 12/6/10 with a recent readmission on 9/3/16 with diagnoses that included but were not limited to: diabetes, high blood pressure, stroke, osteoarthritis, lymphoma (cancer of the lymph system (1)), and anemia.

The most recent MDS (minimum data set)

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	495401	A. BUILDING _____ B. WING _____	C 03/02/2017

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assessment, a quarterly assessment, with and assessment reference date of 12/9/16 coded the resident as being severely impaired to make daily decisions. The resident was coded as being totally dependent upon the staff for all of her activities of daily living.

Review of the clinical record revealed a paper with another resident's name, date of birth, doctor's name, and medical information.

On 3/1/17 at 2:09 p.m. the paper with the other resident's name was shown to administrative staff member (ASM) #2, the director of nursing. When asked if this was a previous or current resident, ASM #2 stated, "I believe this was a previous resident." When asked if this should be in Resident #9's clinical record, ASM #2 stated, "No." When asked who filed reports and documents in the clinical record, ASM #2 stated, "A lot of people; nurse's medical records, unit manager."

The administrator, ASM #1, ASM #2 and ASM #3, the corporate nurse, were made aware of the above findings on 3/1/17 at 4:37 p.m.
A policy on a complete and accurate clinical record was requested.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman Page 346