OP

WADDELL NURSING
AND REHABILITATION CENTER

202 Painter Street
Galax, VA 24333
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April 25, 2016

Rodney L. Miller
Long Term Care Supervisor
Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485

Re: Waddell Nursing & Rehab Center
SNF/NF 49-5126
Plan of Correction

Mailed: 4/25/16

Dear Mr. Miller:

Please find enclosed the Plan of Correction submitted by Waddell Nursing and Rehab Center for the Standard Survey ending on March 31, 2016. The facility received the 2567 Statement of Deficiencies on April 18, 2016 via E-Mail.

The submitted Plan of Correction will serve as the facility's allegation of compliance with the requirements of 42 CFR, Part 483, Subpart B for long term care facilities.

Please feel free to contact me if you have any questions or need any additional information at 276-236-5164.

Respectfully,

James R. Wooddell
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495126	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADDELL NURSING AND REHAB CENTER	202 PAINTER ST GALAX, VA 24333

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/29/16 through 03/31/16. 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 135 certified bed facility was 122 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and 3 closed record reviews (Residents #22 through #24).	F 000	This Plan of Correction will serve as the facility's allegation of compliance with the requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of the plan of correction is in response to the CMS 2567 for the survey and does not constitute an agreement or admission by Waddell Nursing and Rehab Center of the truth of the facts alleged or correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. Waddell Nursing and Rehab Center contends that it was in substantial compliance with the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, Waddell Nursing and Rehab Center submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully complete in all areas as of May 13, 2016	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This Requirement is not met as evidenced by: Based on observation, and staff interview it was determined the facility staff failed to maintain a safe, clean, comfortable and homelike environment in individual resident rooms on 2 of 3 units. Findings: During the initial tour and the subsequent three day onsite survey environmental issues were identified. The surveyors observed the resident rooms were clean on unit 1, but not clean on units 2 & 3. Resident rooms were observed to have dirt and debris build up on the floors and around the	F 252	F 252: 1) Bathrooms and resident rooms 103, 104, 105, 106, 107, 114, 115, 117, 119, 120, 201, 202, 203, 204, 205, 206, 207, 208, 209, 211, 212, 213, 214, 220, and 222 were cleaned to remove the dirt and debri on the floors and at the base of the floor vinyl tile in the bathrooms and resident rooms listed. All bathroom and resident room floor vinyl tile was repaired and reattached in rooms 103, 104, 105, 106, 107, 114, 115, 117, 119, 120, 201, 202, 203, 204, 205, 206, 207, 208, 209, 211, 212, 213, 214, 220, and 222. Bathroom and resident room walls in 103,	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James B Waddell	administrator	4/25/16

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

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F 252	Continued From page 1 bottom edges of the vinyl baseboards in the bathrooms. The vinyl baseboards were observed to be warping and pulling away from the walls in rooms and bathrooms. Paint was scraped and chipped on the walls of bedrooms and needed repair. These conditions were observed in varying degrees in rooms #103, 104, 105,106, 107, 114, 115, 116, 117, 119, 120, 201, 203, 202, 204, 206, 208, 205, 207, 209, 211, 213, 212, 214, 222, & 220. The DON and administrator were informed on 3/31/16 at 12:15 PM. They had no comment.	F 252	104, 105, 106, 107, 114, 115, 117, 119, 120, 201, 202, 203, 204, 205, 206, 207, 208, 209, 211, 212, 213, 214, 220, and 222 were repaired and painted. This was completed on April 22, 2016. 2) All facility bathrooms and resident rooms were inspected for dirt and debri on the floors and at the base of the floor vinyl tile, loose baseboard vinyl tile, wall scraps and chipped paint and was mopped, cleaned, reattached, repaired and painted as necessary. Completed on 4/18/16. 3) The Housekeeping Supervisor and Maintenance Director met with their department staff on 4/8/16 to implement a facility-cleaning and repair program. 4) The Housekeeping Supervisor and Maintenance Director will inspect the bathrooms and resident rooms daily to assure that the resident's bathrooms and rooms will be maintained in a sanitary, orderly and comfortable condition. Identified areas will be addressed and corrected. 5) The facility administrator and management team will conduct a daily facility inspection by assigned and selected units and floors, which will cover the entire facility at least each month to maintain a sanitary, orderly, and comfortable	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications;	F 272		

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F 272	Continued From page 2 Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This Requirement is not met as evidenced by: Based on staff interview and clinical record review it was determined the facility staff failed to ensure the completion of a comprehensive, accurate, CAA (Care Area Assessment) of each resident's functional capacity for 13 of 24 residents. (Resident's # 5, 13, 4, 10, 14, 1, 3, 9, 11, 2, 6, 7, & 19). Findings: 1. Facility staff failed to complete an accurate CAA (Care Area Assessment) summary for Resident #5. The resident's clinical record was reviewed on 3/30/16 at 10:30 AM. Resident # 5 was admitted to the facility on 10/23/12. The diagnoses included dementia, diabetes, coronary artery disease and cerebral vascular accident, end-stage renal disease, anxiety and depression. The resident's annual MDS (minimum data set) assessment dated 06/18/15 coded the resident with slightly impaired cognitive ability. Resident #5 required staff assistance for all ADL (activities of	F 272	interior. Identified issues will be discussed with the Housekeeping Supervisor and Maintenance Director for correction. F 272 1) Residents numbers 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 13, and 19 CAAs (care area assessment) summaries were update to reflect where, in the clinical record, the location and date of information related to the CAA can be found and for each triggered CAA. This was accomplished on 4/8/16. 2) A 100% audit of all residents CAAs was conducted and concluded on 4/22/16 by the care plan team and the location and date of information related to the CAAs was found in or corrected at that time in the clinical record for each triggered CAA for each current resident. 3) In-service education was provided to the care plan team on 4/13/16 addressing the documentation requirements concerning assessment information in support of clinical decision making relevant to the CAA, documentation	5/13/16

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F 272	Continued From page 3 daily living.) The MDS contained CAA's signed and dated 07/01/15. The location and date section (Section V) of the CAA documentation was observed to be incomplete for location and dates of the summarized material for CAA documentation. This information was shared with the DON and administrator on 3/30/16 at 4:45 PM. No additional info was provided. 2. Facility staff failed to complete an accurate CAA (Care Area Assessment) summary for Resident #13. The resident's clinical record was reviewed on 3/30/16 at 9:00 AM. Resident # 13 was admitted to the facility on 09/16/14. The diagnoses included traumatic brain injury, paraplegia, atrial fibrillation, hypertension, anxiety and psychosis. The resident's annual MDS (minimum data set) assessment dated 08/27/15 coded the resident with unimpaired cognitive ability. Resident #13 required staff assistance for all ADL (activities of daily living.) The MDS contained CAA's signed and dated 09/03/15. The location and date section (Section V) of the CAA documentation was observed to be incomplete for location and dates of the summarized material for CAA documentation. This information was shared with the DON and administrator on 3/30/16 at 4:45 PM. No additional info was provided. 3. For Resident #4, the facility staff failed to	F 272	regarding where, in the clinical record, the location and date of information related to the CAA can be found for each triggered CAA. 4) The facility has implemented a new Electronic Health Record effective March 1, 2016 which will assist with accurately documenting the location and date section (Section V) of the CAA for location and date of the summarized material for CAA documentation. 5) The facility administrator will attend 25% of the monthly interdisciplinary care plan team meetings to monitor for compliance of the CAA summaries with containing the location and date of information in the clinical record for each triggered CAA.	5/13/16

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include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment.

Resident #4 was admitted to the facility 11/23/15. Diagnoses included, but were not limited to, diabetes, anemia, nutritional deficiency, dementia with behavioral disturbances, hypertension, and insomnia.

Section C (cognitive patterns) of the Resident annual MDS assessment with an ARD (assessment reference date) of 10/22/15 included a documented summary score of 5 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented see CAA summary 10/23/15 and 10/26/15. The actual location(s) had not been documented.

On 03/30/16 at approximately 1:20 p.m. LPN (licensed practical nurse) #1 was asked about the missing documentation in section V. LPN #1 verbalized to the surveyors that she had been taught to do it that way when she attended training on the computer system.

The administrator, DON (director of nursing), ADON (assistant director of nursing), and staff development coordinator were notified of the missing information in section V of the Residents annual MDS assessment in a meeting with the survey team on 03/30/16 at approximately 4:35 p.m.

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

4. For Resident #10, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment.

Resident #10 was admitted to the facility 03/14/14. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, respiratory failure, sleep apnea, hypertension, and hyperglycemia.

Section C (cognitive patterns) of the Residents annual MDS assessment with an ARD (assessment reference date) of 06/24/15 included a documented summary score of 14 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented see CAA summary and had documented the dates of 06/05/15, 06/08/15, and 06/09/15. The actual location(s) had not been documented.

On 03/30/16 at approximately 1:20 p.m. LPN (licensed practical nurse) #1 was asked about the missing documentation in section V. LPN #1 verbalized to the surveyors that she had been taught to do it that way when she attended training on the computer system.

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The administrator, DON (director of nursing), ADON (assistant director of nursing), and staff development coordinator were notified of the missing information in section V of the Residents annual MDS assessment in a meeting with the survey team on 03/30/16 at approximately 4:35 p.m.

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

5. For Resident #14, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment.

Resident #14 was admitted to the facility 12/04/14. Diagnoses included, but were not limited to, anemia, dementia, mood disorder, depression, hypertension, and chronic pain.

Section C (cognitive patterns) of the Residents annual MDS assessment with an ARD (assessment reference date) of 11/19/15 included a documented summary score of 8 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented see CAA summary and had documented the dates of 11/20/15 and 11/23/15. The actual location(s) had not been documented.

On 03/30/16 at approximately 1:20 p.m. LPN (licensed practical nurse) #1 was asked about the

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missing documentation in section V. LPN #1 verbalized to the surveyors that she had been taught to do it that way when she attended training on the computer system.

The administrator, DON (director of nursing), ADON (assistant director of nursing), and staff development coordinator were notified of the missing information in section V of the Residents annual MDS assessment in a meeting with the survey team on 03/30/16 at approximately 4:35 p.m.

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

6. For Resident #1 the facility staff failed to ensure an accurate comprehensive MDS (minimum data set) assessment.
Resident #1 was admitted to the facility on 04/17/14 and readmitted on 01/21/16. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, peripheral vascular disease, gastroesophageal reflux disease, urinary tract infection, diabetes mellitus, hyperlipidemia, anxiety, depression, bipolar disorder, chronic obstructive pulmonary disease, and dysphagia.
The most recent comprehensive MDS with and ARD (assessment reference date) of 01/28/16 coded the Resident as 14 of 15 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was " see CAA summary 02/02/16 " .
The MDS coordinator was interviewed on 03/30/16 at approximately 1320. She stated that is how they were taught during MDS training.

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The administrator, director of nursing, MDS coordinator, and staff development were informed of the findings during a meeting with the survey team on 03/30/16 at 1640.
No further information was provided prior to exit.

7. For Resident #3 the facility staff failed to ensure an accurate comprehensive MDS assessment.
Resident #3 was admitted to the facility on 10/20/15 and readmitted on 11/11/15. Diagnoses included but not limited to anemia, hypertension, multi drug resistant organism, seizure disorder, malnutrition, deep venous thrombosis, anxiety disorder, chronic obstructive pulmonary disorder, respiratory failure, dysphagia, gastroesophageal reflux disease, and end stage renal disease.
The most recent MDS with an ARD of 01/13/16 coded the Resident as 9 out of 15 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed.
The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was " see CAA summary 10/30/15 " .
The MDS coordinator was interviewed on 03/30/16 at approximately 1320. She stated that is how they were taught during MDS training.
The administrator, director of nursing, MDS coordinator, and staff development were informed of the findings during a meeting with the survey team on 03/30/16 at 1640.
No further information was provided prior to exit.

8. For Resident #9 the facility staff failed to ensure an accurate comprehensive MDS assessment.
Resident #9 was admitted to the facility on 02/09/15. Diagnoses included but not limited to anemia, congestive heart failure, hypertension,

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gastroesophageal reflux disease, end stage renal disease, thyroid disorder, osteoporosis, Alzheimer ' s disease, dementia, anxiety, depression, and psychotic disorder.
The most recent MDS with an ARD of 01/21/16 coded the Resident as 0 of 15 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was " see CAA summary 01/25/16 " .
The MDS coordinator was interviewed on 03/30/16 at approximately 1320. She stated that is how they were taught during MDS training.
The administrator, director of nursing, MDS coordinator, and staff development were informed of the findings during a meeting with the survey team on 03/30/16 at 1640.
No further information was provided prior to exit.

9. For Resident #11 the facility staff failed to ensure an accurate comprehensive MDS assessment.
Resident #11 was admitted to the facility on 03/16/05 and readmitted on 05/26/15. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, depression, bipolar disorder, gastroesophageal reflux disease, chronic kidney disease, coronary artery disease, osteoporosis, and psychotic disorder.
The most recent MDS with an ARD of 03//03/16 coded the Resident as 10 out of 15 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was " see CAA summary 09/18/15 " .

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The MDS coordinator was interviewed on 03/30/16 at approximately 1320. She stated that is how they were taught during MDS training.
The administrator, director of nursing, MDS coordinator, and staff development were informed of the findings during a meeting with the survey team on 03/30/16 at 1640.
No further information was provided prior to exit.
10. The facility staff failed to document the location of where the documentation could be found in Resident #2 ' s clinical record for Section V of the Care Area Assessment (CAA) Summary of the Minimum Data Set (MDS).
Resident #2 was readmitted to the facility on 5/22/15 with the following diagnoses of, but not limited to anemia, high blood pressure, diabetes, dementia, anxiety, dysphagia and insomnia. The most recent MDS was a quarterly assessment with an ARD (Assessment Reference Date) of 12/31/15 scored the resident of having a BIMS (Brief Interview of Mental Status) score of 3 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 or more staff members for bathing and personal hygiene.
The surveyor reviewed the clinical record of Resident #2 on 3/30/16. The surveyor noted that on the annual MDS with an ARD of 10/8/15 in Section V of the CAA Summary the location of the documentation to support the triggered area for the following were missing: Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence/Indwelling Catheter, Falls, Nutritional Status, Dental Care, Pressure Ulcer and Psychotropic Drug Use.
The MDS nurse was interviewed on 3/30/16 at approximately 3 pm in the conference room and was notified of the above documented findings.
The MDS nurse stated " We were told as long as we put See CAA Summary with a date, that it was

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alright. "
The administrator, director of nursing and assistant director of nursing was notified of the above documented findings in the end of the day conference on 3/30/16 at approximately 4pm.
No further information was provided to the surveyor prior to the exit conference on 3/31/16.

11. The facility staff failed to document the location of where the documentation could be found in Resident #6 ' s clinical record for Section V of the Care Area Assessment (CAA) Summary of the Minimum Data Set (MDS).
Resident #6 was admitted to the facility on 1/15/13 with the following diagnoses of, but not limited to anemia, high cholesterol, major depressive disorder, general anxiety, pain, and high blood pressure. The most recent MDS was a quarterly assessment with an ARD (Assessment Reference Date) of 1/21/16 scored the resident of having a BIMS (Brief Interview of Mental Status) score of 9 out of a possible score of 15. The resident was also coded as requiring total dependent on the assistance of 2 or more staff members for bathing and personal hygiene. Resident #6 was also coded as being always incontinent of bowel and bladder.
The surveyor reviewed the clinical record of Resident #6 on 3/29/16. The surveyor noted that on the annual MDS with an ARD of 10/29/15 in Section V of the CAA Summary the location of the documentation to support the triggered area for the following were missing: Cognitive Loss/Dementia, Visual Function, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence/Indwelling Catheter, Psychosocial Well-Being, Mood, Activities, Falls, Nutritional Status, Dental Care, Pressure Ulcer, Psychotropic Drug Use and Pain.
The MDS nurse was interviewed on 3/30/16 at

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approximately 3 pm in the conference room and was notified of the above documented findings.
The MDS nurse stated " We were told as long as we put See CAA Summary with a date, that it was alright. "
The administrator, director of nursing and assistant director of nursing was notified of the above documented findings in the end of the day conference on 3/30/16 at approximately 4pm.
No further information was provided to the surveyor prior to the exit conference on 3/31/16.

12. The facility staff failed to document the location of where the documentation could be found in Resident #7 ' s clinical record for Section V of the Care Area Assessment (CAA) Summary of the Minimum Data Set (MDS).
Resident #7 was readmitted to the facility on 12/27/15 with the following diagnoses of, but not limited to coronary artery disease, heart failure, high blood pressure, diabetes, high cholesterol, asthma, low potassium, and respiratory failure.
The annual MDS with an ARD (Assessment Reference Date) of 1/28/16 scored the resident of having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible score of 15. The resident was also coded as requiring only supervision of one staff member for transfers, dressing and personal hygiene.
The surveyor reviewed the clinical record of Resident #7 on 3/30/16. The surveyor noted that on the above mentioned annual MDS in Section V of the CAA Summary the location of the documentation to support the triggered area for the following were missing: ADL Function/Rehabilitation Potential, Falls, Nutritional Status, Dental Care, Pressure Ulcer, and Pain.
The MDS nurse was interviewed on 3/30/16 at approximately 3 pm in the conference room and was notified of the above documented findings.

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The MDS nurse stated " We were told as long as we put See CAA Summary with a date, that it was alright. "
The administrator, director of nursing and assistant director of nursing was notified of the above documented findings in the end of the day conference on 3/30/16 at approximately 4pm.
No further information was provided to the surveyor prior to the exit conference on 3/31/16.
13. The facility staff failed to document the location of where the documentation could be found in Resident #19 ' s clinical record for Section V of the Care Area Assessment (CAA) Summary of the Minimum Data Set (MDS).
Resident #19 was readmitted to the facility on 1/27/16 with the following diagnoses of, but not limited to anemia, high blood pressure, anxiety, depression, respiratory failure, heart failure, muscle weakness and Stage III kidney disease.
The most recent MDS was a quarterly assessment with an ARD (Assessment Reference Date) of 2/4/16 scored the resident of having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible score of 15. The resident was also coded as requiring limited assistance of 1 staff member for transfers, and ambulation. The resident is coded as needing the assistance for set up only with eating.
The surveyor reviewed the clinical record of Resident #19 on 3/31/16. The surveyor noted that on the significant change MDS with an ARD of 10/30/15 in Section V of the CAA Summary the location of the documentation to support the triggered area for the following were missing: ADL Functional/Rehabilitation Potential, Urinary Incontinence/Indwelling Catheter, Mood State, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, Psychotropic Drug Use and Pain.
The MDS nurse was interviewed on 3/31/16 at

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F 272	Continued From page 14 approximately 10 am in the conference room and was notified of the above documented findings. The MDS nurse stated " We were told as long as we put See CAA Summary with a date, that it was alright. " The administrator, director of nursing and assistant director of nursing was notified of the above documented findings in the end of the day conference on 3/31/16 prior to the exit conference. No further information was provided to the surveyor prior to the exit conference on 3/31/16.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278	F 278: 1) Resident #3 MDS coding to reflect the accurate height statues was added and corrected on 4/1/16. Resident #11 MDS coding to reflect accurate range of motion was added and corrected on 4/1/16. 2) All residents with heights and functional range of motion MDS records were reviewed was completed on 4/8/16 by the MDS coordinators and found to be accurately coded with no corrections necessary. 3) The DON and DSD provided in-service education to the members of the care planning team on the MDS and care planning requirements and accurate assessments on 4/13/16.	

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F 278	Continued From page 15 Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: Based on staff interview and clinical document review the facility staff failed to ensure a complete and accurate MDS (minimum data set) assessment for 2 of 24 Residents, Residents #3 and #11. The findings included: 1. For Resident #3 the facility staff failed to accurately record the height on the MDS. Resident #3 was admitted to the facility on 10/20/15 and readmitted on 11/11/15. Diagnoses included but not limited to anemia, hypertension, multi drug resistant organism, seizure disorder, malnutrition, deep venous thrombosis, anxiety disorder, chronic obstructive pulmonary disorder, respiratory failure, dysphagia, gastroesophageal reflux disease, and end stage renal disease. The most recent quarterly MDS with an ARD of 01/13/16 coded the Resident as 9 out of 15 in Section C, cognitive patterns. Section K, swallowing/nutrition status was also reviewed. It recorded the Resident ' s height as 60 " . The most recent comprehensive MDS with an ARD of 10/27/15 recorded the Resident ' s height as 62 " in Section K. The MDS coordinator was interviewed on 03/31/16 at approximately 1100. She stated that she did not know why the Resident ' s height was different, but she would check to see. The RD (registered dietitian) spoke with the surveyor on 03/31/16 at approximately 1130 and provided surveyor with a list that showed Resident height measurements per each MDS assessment. The admission, 14-day, and readmission MDS all recorded the Resident ' s height as 62 " , while the 5-day, 14-day (after readmission), 30-day and	F 278	4) The DON and Administrator will attend at least a monthly care planning conference and will review the MDS / care plan information for accuracy. Any identified areas will be discussed with the interdisciplinary care plan team and Risk Management Committee. 5) Risk Management Committee will monitor compliance and report findings to the quarterly Quality Assurance Committee for action and follow up as necessary.	5/13/16

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F 278	Continued From page 16 60-day MDS recorded the Resident ' s height as 60 " . RD stated the CNA (certified nurse ' s aide) team was responsible for obtaining Resident heights. Surveyor spoke with the DON (director of nursing) regarding how Resident heights were obtained, and she stated that for Resident #3, she would have been measured lying down. The concern of the incorrect heights was brought to the attention of the administrative staff during a meeting on 03/31/15 at approximately 1230. No further information was provided prior to exit. 2. For Resident #11 the facility staff failed to ensure an accurate MDS assessment in regards to " range of motion " . Resident #11 was admitted to the facility on 03/16/05 and readmitted on 05/26/15. Diagnoses included but not limited to anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, depression, bipolar disorder, gastroesophageal reflux disease, chronic kidney disease, coronary artery disease, osteoporosis, and psychotic disorder. The most recent quarterly MDS with an ARD of 03//03/16 coded the Resident as 10 out of 15 in Section C, cognitive patterns. Section G, function status coded the Resident as no impairment to either upper or lower extremities. The most recent comprehensive MDS coded the Resident as having impairment bilaterally to both upper and lower extremities.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	1) The attending physicians for residents #2 was contacted on 3/30/16 and advised that the blood pressure was not obtained and recorded for the week of 3/1/316 – 3/17/16. The attending physician for resident #2 did not provide any additional orders or change of orders. 2) A 100% review of resident charts was conducted by the professional nursing staff	

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F 309	Continued From page 17 This Requirement is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow obtaining physician ordered blood pressures for 1 of 24 residents. (Resident #2) The findings included: The facility staff failed to obtain physician ordered blood pressures weekly for Resident #2. Resident #2 was readmitted to the facility on 5/22/15 with the following diagnoses of, but not limited to anemia, high blood pressure, diabetes, dementia, anxiety, dysphagia and insomnia. The most recent MDS was a quarterly assessment with an ARD (Assessment Reference Date) of 12/31/15 scored the resident of having a BIMS (Brief Interview of Mental Status) score of 3 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 or more staff members for bathing and personal hygiene. During the clinical record review of the resident ' s chart, it was noted that the physician had ordered weekly blood pressures starting on February 4, 2016. The weekly blood pressures were obtained from 2/4/16 to 3/3/16 on a weekly basis. On 3/10/16 and 3/17/16 there were no blood pressures obtained. Then on 3/24/16 there was a weekly blood pressure obtained and documented. The administrator, director of nursing and assistant director of nursing was notified of the above documented findings on 3/30/16 in the end of the day at approximately 4 pm. No further information was provided to the surveyor prior to the exit conference.	F 309	completed on 4/5/16 and found no residents were without obtained B/Ps as appropriate and the attending physicians were notified of this on 4/5/16. 3) In-service education was provided by the Director of Staff Development for the professional nursing staff on 4/20/16 and 4/21/16 covering proper procedures for processing and following physician orders and notifications to the attending physician of any missed orders. 4) The DON, ADON, and DSD will monitor daily new physician and renewed physician orders in the physician order section of the electronic health records and will monitor 20% of resident records for verification and monitoring of compliance with physician orders by the professional nursing staff and accurate reflection in the MARs and TARs. The DON will present findings to the Administrator monthly and will provide a summary to the Quality Assurance Committee for necessary monitoring and follow up.	5/13/16
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 18 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: Based on observation, Resident interview, staff interview and clinical record review the facility staff failed to follow physician's orders for pressure ulcer prevention for 1 of 24 Residents, Resident #3 The findings included: For Resident #3 the facility staff failed to ensure Resident was wearing physician ordered bunny boots. Resident #3 was admitted to the facility on 10/20/15 and readmitted on 11/11/15. Diagnoses included but not limited to anemia, hypertension, multi drug resistant organism, seizure disorder, malnutrition, deep venous thrombosis, anxiety disorder, chronic obstructive pulmonary disorder, respiratory failure, dysphagia, gastroesophageal reflux disease, and end stage renal disease. The most recent quarterly MDS with an ARD of 01/13/16 coded the Resident as 9 out of 15 in Section C, cognitive patterns. Section M, skin conditions, coded the Resident as high risk for developing pressure ulcers. Resident #3's CCP (comprehensive care plan) was reviewed on 03/30/16. It contained a care	F 314	F314 1) Protective padded booties were placed on residents #3 and the residents heels were floated off the bed when in bed on 3/30/16. 2) 100% of residents with orders for protective padded booties were reviewed on 4/1/16 by professional nursing staff and all were found to have protective padded booties in place. 3) In-service education was provided to all nursing staff on the procedure for application and monitoring of residents with orders for protective padded booties and this was conducted and concluded on 4/6/16. 4) In-service education has been conducted and concluded for nursing staff on 4/22/16 on assessing, reviewing and implementation of the daily assignment information. 5) The DON, ADON and DSD will monitor daily the alert tracking and trending section of the electronic health record for assessing 100% compliance with daily assignments. The RN Unit Supervisor will monitor daily all residents for applications of protective padded booties.	

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F 314	Continued From page 19 plan for "Skin Integrity Needs". Interventions under this care plan were "Bunny boots qshift". Resident #3's clinical record was reviewed on 03/30/16. It contained a physician' order summary for March 2016 which read in part "bunny boots q shift every shift". Surveyor observed Resident #3 on 03/30/16 at approximately 1240. Resident was sitting up in bed, eating lunch. Surveyor asked Resident #3 if she had her boots on and Resident stated "no I don't, they are over there" and pointed to wardrobe. Surveyor then went to unit nurse and asked her to accompany surveyor to Resident #3's room. Surveyor asked unit nurse to check if Resident had her bunny boots on. Resident did not have bunny boots on, and unit nurse was unable to locate them in Resident's room. Unit nurse stated that boots were most likely in the laundry, and she would call and get another pair sent. The concern of the missing bunny boots was brought to the attention of the administrative staff during a meeting on 03/31/15 at approximately 1230. No further information was provided prior to exit.	F 314	6) The DON will present findings to the Quality Assurance Committee for necessary monitoring and follow up.	5/13/16
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315	1) The attending physicians for residents #3 was contacted on 3/30/16 and advised that the urinary output was not obtained and recorded on multiple occasions in the TAR. The attending physician for resident #3 did not provide any additional orders or change of orders. 2) A 100% review of resident charts was conducted by the professional nursing staff completed on 4/4/16 and	

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F 315	Continued From page 20 function as possible. This Requirement is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to record foley catheter output for 1 of 24 Residents, Resident #3. The findings included: For Resident #3 the facility staff failed to record foley catheter output. Resident #3 was admitted to the facility on 10/20/15 and readmitted on 11/11/15. Diagnoses included but not limited to anemia, hypertension, multi drug resistant organism, seizure disorder, malnutrition, deep venous thrombosis, anxiety disorder, chronic obstructive pulmonary disorder, respiratory failure, dysphagia, gastroesophageal reflux disease, and end stage renal disease. The most recent quarterly MDS with an ARD of 01/13/16 coded the Resident as 9 out of 15 in Section C, cognitive patterns. Section H, bowel and bladder coded the Resident as having an indwelling foley catheter. Resident #3's CCP (comprehensive care plan was reviewed on 03/30/15. It contained a care plan for "Urinary Device". Interventions listed for this care plan included "Foley Output-record amount q shift (every)." Resident #3's clinical record was reviewed on 03/30/16. It contained a physician' order summary for March 2016 which read in part "record foley output every shift for monitoring". Resident #3's TAR (treatment administration record) for March was reviewed and contained an entry which read in part "Record foley output every shift for	F 315	found no residents were without obtained urinary output as appropriate and the attending physicians were notified of this on 4/4/16. 3) In-service education was provided by the Director of Staff Development for the professional nursing staff on 4/20/16 and 4/21/16 covering proper procedures for processing and following physician orders and notifications to the attending physician of any missed orders. 4) The DON, ADON, and DSD will monitor daily new physician and renewed physician orders in the physician order section of the electronic health records and will monitor 20% of resident records for verification and monitoring of compliance with physician orders by the professional nursing staff and accurate reflection in the MARs and TARs. The DON will present findings to the Administrator monthly and will provide a summary to the Quality Assurance Committee for necessary monitoring and follow up.	5/13/16

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F 315	Continued From page 21 monitoring". This entry contained multiple blank areas where nothing was recorded. The TAR was shown to the DON (director of nursing) and staff development nurse on 03/30/16 at approximately 1430. DON stated the nurses had been having some problems with documenting since they had changed echarting programs. She stated the new program had only been in use 30 days, and everyone was still learning it. The concern over the missing foley output was brought to the attention of the administrative staff during a meeting on 03/31/16 at approximately 1230. No further information was provided prior to exit.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: Based on observation and staff interview it was determined the facility staff failed to keep the resident's environment free of accident hazards. Findings: 1. On 3/30/16 at 4:00 PM the following observations were made in the Unit II shower room--which was found to be unlocked when the surveyor entered: a. A one gallon plastic jug of "Betco Disinfectant	F 323	F323 1) Disinfectant and skin lotion was removed and placed into a locked cabinet in the shower room on 3/30/16. 6 containers of Clorox wipes, 70 clean razors, 6 moisture barrier creams, and 1 box of skin prep were removed from the main floor clean utility room and store under lock. This was done on 3/30/16. 2) The Housekeeping Supervisor inspected all shower rooms on 3/31/16 and found none with any unlocked disinfectant or Clorox wipes, razors, moisture barriers creams or skin prep and did not find any items deemed hazardous.	

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F 323	Continued From page 22 & Floor Cleaner" (PH7Q) was found on the shower floor underneath an overbed table. The label indicated "Danger--corrosive, causes irreversible eye damage. Avoid contact with skin. Harmful if inhaled. b. A one gallon bottle of D "Derma Science" skin care lotion was also left on the floor of the shower by staff members. The label cautioned "external use only." c. An unidentified yellow liquid contained in a spray bottle hanging about four feet off the floor next to the tub was also found. CNA I was found at the nursing desk and asked if the showers were done for the day. CNA I said they are done "for now" but said second shift would be doing some later in the evening. CNA I was asked to accompany the surveyor into the shower room to identify the items found there. CNA I told the surveyor the fluid in the spray bottle was PH7Q-- the disinfectant and floor cleaner contained in the large gallon bottle. CNA I said they were supposed to lock up the large gallon containers when they were not in the shower room--but they generally left the spray bottle on the hook where it was found. The DON and administrator were informed of these findings at 3/31/16 at 12:15 PM. 2. The facility staff failed to keep the Clean Utility room on the main floor which contained hazardous materials locked at all times. On 3/30/16 at 10:20 am, the surveyor and the assistant of nursing found the clean utility room on the main floor in the hallway that was being used by residents unlocked. In this room the surveyor found the following products being stored on the shelves: 6 containers of Clorox wipes, 70 clean razors and 6 moisture barrier	F 323	3) In-service education has been conducted and concluded for nursing staff on 4/15/16 concerning proper storage of hazardous materials within the facility. 4) The Maintenance Director has placed locked storage cabinets in all facility shower rooms and placed locked storage wall cabinets in all clean utility rooms. 5) The RN Unit Manager and Housekeeping Supervisor will monitor daily all shower rooms and clean utility rooms for proper storage of disinfection and other items deemed hazardous 6) The DON, RN Unit Manager and Housekeeping Supervisor will present findings to the Quality Assurance Committee for necessary monitoring and follow up.	5/13/16

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	495126	A. BUILDING _____ B. WING _____	03/31/2016

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F 323	Continued From page 23 creams and 1 box of skin prep. On these products that was a warning that stated " Keep out of the reach of children " . Also, noted was the warning that stated " If ingested, drink large amounts of water. Call Physician. " The assistant director of nursing was asked about if this door should remain locked if these products had the above documented warnings on them. The assistant director stated " No I guess not. " An observation was made on 3/31/16 at 10 am and the door to this clean utility room on the main floor was locked. The surveyor on the survey team that was assigned the task of Environmental Rounds were notified of each of these observations as they were made by this surveyor. On 3/30/16 at approximately 4 pm in the end of the day conference, the administrator and director of nursing was notified of the above documented findings. The director of nursing stated " That door has never been kept locked. " No further information was provided to the surveyor prior to the exit conference on 3/31/16.	F 323		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This Requirement is not met as evidenced by: Based on staff interview and clinical record review, the facility staff obtained unnecessary lab tests for 2 of 24 Residents, Residents #10 and #14. The findings included. 1. For Resident #10, the facility staff obtained the	F 504	F 504 1) The attending physician for resident #10 and #14 was contacted on 3/30/16 and advised that an H & H (hemoglobin and hematocrit) was obtained on resident #10 and that a digoxin level was obtained on resident #14 after the digoxin was discontinued. No new orders or change of orders were provided by the attending physician.	

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F 504	Continued From page 24 lab test H & H (hemoglobin and hematocrit) without a physicians order. Resident #10 was admitted to the facility 03/14/14. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, respiratory failure, sleep apnea, hypertension, and hyperglycemia. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/11/16 included a documented summary score of 14 out of a possible 15 points. The Residents clinical record included a copy of the lab test H & H that was dated 02/01/16. During the record review the surveyor was unable to locate a physicians order for this lab test. On 03/30/16 at approximately 10:30 a.m. LPN (licensed practical nurse) #2 was asked about the lab test. On 03/3-16 at approximately 1:50 p.m. LPN #2 verbalized to the surveyor that she was unable to find a physicians order for this lab. On 03/30/16 at approximately 4:35 p.m., during a meeting with the survey team, the administrator, DON (director of nursing), ADON (assistant director of nursing), and staff development coordinator were notified that the lab test H & H was obtained on Resident #10 without a physicians order. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 504	2) A 100% review of resident charts was conducted by the professional nursing staff completed on 3/31/16 and found no residents with non-physician ordered laboratory tests. 3) The facility has implemented a new Electronic Health Record which will provide daily alert and scheduled tracking information for laboratory testing. The unit secretary will monitor the tracking information daily and will prepare the appropriate laboratory paper work to be acknowledged by the charge nurse. The RN Unit Supervisor will monitor 100% of resident charts for completion of scheduled and physician ordered laboratory tests. 4) The DON and ADON will monitor daily the alert tracking and trending section of the electronic health records and will monitor 100% of resident records for necessary laboratory results. The DON will present findings to the Quality Assurance Committee for necessary monitoring and follow up.	5/13/16

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F 504	Continued From page 25	F 504		

2. For Resident #14, the facility staff obtained a digoxin level lab test on 02/26/16. The Residents digoxin medication had been discontinued in November 2015.

Resident #14 was admitted to the facility 12/04/14. Diagnoses included, but were not limited to, anemia, dementia, mood disorder, depression, hypertension, and chronic pain.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/11/16 included a documented summary score of 14 out of a possible 15 points.

The Residents clinical record included the results of a digoxin lab test obtained on 02/26/15. The results were documented as < (less than) 0.20. The reference range on this lab was documented as 0.9-2.0.

On 03/30/16 LPN #2 was asked about the digoxin lab test. After reviewing the clinical record LPN #2 verbalized to the surveyor that it did look like the medication digoxin had been discontinued and she wasn't sure why the lab test had been obtained.

On 03/30/16 at approximately 4:35 p.m., during a meeting with the survey team, the administrator, DON (director of nursing), ADON (assistant director of nursing), and staff development coordinator were notified of the above.

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

F 514 SS=D 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB — F 514

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F 514	Continued From page 26 LE	F 514	F 514:	

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

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

This Requirement is not met as evidenced by:
Based on observation, Resident interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 1 of 24 Resident's, Resident #3.

The findings included:

For Resident #3 the facility staff failed to ensure complete and accurate MAR (medication administration record) and TAR (treatment administration record).

Resident #3 was admitted to the facility on 10/20/15 and readmitted on 11/11/15. Diagnoses included but not limited to anemia, hypertension, multi drug resistant organism, seizure disorder, malnutrition, deep venous thrombosis, anxiety disorder, chronic obstructive pulmonary disorder, respiratory failure, dysphagia, gastroesophageal reflux disease, and end stage renal disease. The most recent quarterly MDS with an ARD of 01/13/16 coded the Resident as 9 out of 15 in Section C, cognitive patterns.

F 514:

1) Resident #3's MAR record was reviewed and corrected to reflect the actual physician order "ensure one time a day for Protein Calorie Malnutrition" and "maintain catheter drainage bag below the bladder level" on the TAR was reviewed and corrected by the floor nurse. This was completed on 3/31/16 as late entry noted in the medical records.
2) Resident MAR and TAR records were reviewed by the licensed professional nurse on each floor and by the ADON completed on 4/6/16 and found all MAR and TAR records matched physician orders and signed by the nurse. No corrections were necessary.
3) In-service education concerning the policy for medication administration and testament administration records and accuracy per physician orders and a completed accurate medical record was conducted on 4/20/160and 4/21/16 by the DON and DSD.
4) The Unit Managers will monitor the resident's MAR and TAR record daily and review the electronic health record to-do list for accuracy and completion of the resident's medical record.

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F 514	Continued From page 27 Resident #3's clinical record was reviewed on 03/30/16. It contained a physician' order summary for March 2016 which read in part "Ensure one time a day for Protein Calorie Malnutrition" and "maintain catheter drainage bag below bladder level". Resident #3's MAR for March were reviewed on 03/30/16. It contained an entry which read in part "Ensure on time a day for Protein Calorie Malnutrition". This entry had not been signed on 03/25/16. Resident #3's TAR (treatment administration record) for March was reviewed on 03/30/16. It contained an entry which read in part "maintain catheter drainage bag below bladder level". This entry had not been signed on 03/25/16. Surveyor observed Resident #3 on 03/30/16 at approximately 1240. Resident was sitting up in bed, eating her lunch. Resident had an open can of Ensure with a straw placed in it on her lunch tray. Surveyor asked Resident if she always had Ensure with her lunch and Resident stated "every day". Surveyor observed Resident's catheter drainage bag hanging in privacy bag attached to the Resident's bed frame, placing it below bladder level. The concern over the missing documentation was brought to the attention of the administrative staff during a meeting on 03/31/16 at approximately 1230. No further information was provided prior to exit.	F 514	5) The DON, ADON and DSD will conduct daily review of the electronic health record and conduct monthly reviews of 25% of the resident records for compliance with physician orders and medication administration. Results will be shared with the Risk Management Committee. 6) Risk Management Committee will monitor compliance weekly and report findings to the quarterly Quality Assurance Committee for action and follow up as necessary.	5/13/16