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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495280	A. BUILDING _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER AT LAKE RIDGE	12185 CLIPPER DRIVE LAKE RIDGE, VA 22192

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard was conducted 1/11/16 through 1/13/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey

The census in this 60 certified bed facility was 53 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #1 through #12) and 3 closed record reviews (Residents #13, #14 and #15).

F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		

A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
Based on Resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to complete a SCSA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Catherine E Farrow	Administrator	2/5/16

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 274	Continued From page 1 (significant change in status assessment) within 14 days after determination of a change in status for 2 Residents (Residents #3 & #8) of 15 residents in the resident sample. 1. For Resident #3, the facility staff failed to assess the Resident for a significant change in condition after the Resident's functional status in transferring, hygiene, and incontinence changed from extensive assistance to independent or Limited assistance on staff members for Activities of Daily Living (ADL's) for the 6-3-15 assessment, and Ambulation, eating and hygiene for the 12-2-15 assessment. 2. For Resident #8, the facility staff failed to assess the Resident for a significant change in condition after the Resident's cognitive status and functional status in ambulation and bathing changed from total dependence to extensive assistance on staff members for Activities of Daily Living (ADL's) for the 6-8-15 assessment, and cognitive status, ambulation and eating for the 12-2-15 assessment. The findings included: 1. Resident #3 was originally admitted to the facility on 11-17-14 and readmitted on 3-2-15. Diagnoses included Parkinson's disease, multiple fractures, and anemia. Resident #3's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 12-2-15. The Resident was coded with a Brief interview for mental status (BIMS) score of 15 points scored in a possible 15 points, indicating no cognitive impairment. The Resident was	F 274	1. Residents #3 and #8 had comprehensive assessments scheduled and completed on 01/28/16 2. Any resident experiencing a significant change in condition could be affected. The alert charting for residents potentially triggering a change in condition has been reviewed for potential Significant Change Assessment -none were noted. 3. Review of the 2015 version of the RAI manual for guidance on "significant change". 4. The Interdisciplinary team will audit a random sample of 3 MDS monthly x 3 months to determine if a significant change is needed or not. Findings will be reported to QA for further monitoring and modification. 5. Will be completed on 02/23/16	

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F 274	Continued From page 2	F 274		

coded as requiring extensive assistance of staff for ambulation in a wheel chair, and cueing or oversight of staff for eating or hygiene. The Resident was also occasionally incontinent of bladder.

The Most recent Full MDS assessment used for comparison, was an admission full Assessment completed on 3-9-15. The quarterly assessments between the most recent quarterly, and the full assessment were dated 6-3-15, and 9-2-15. All 4 assessments were reviewed for continuity of assessment correctness, as the most recent quarterly assessment, and the full admission assessment had numerous variations in functional ability. The comparisons follow:

The 3-9-15 full admission assessment to the 6-3-15 quarterly assessment revealed the following changes,

3-9-15, Transferring extensive assistance of 1 staff member, Hygiene extensive assist of 1 staff member, occasionally incontinent of bladder.

6-3-15, Transferring limited assistance of 1 staff member, Hygiene oversight or cueing only, no hands on help assist of 1 staff member, frequently incontinent of bladder.

The 9-2-15 quarterly assessment to the 12-2-15 quarterly assessment revealed the following changes;

9-2-15, Ambulation in a wheel chair limited assistance of 1 staff member, eating completely independent, Hygiene limited assist of 1 staff member, frequently incontinent of bladder.

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12-2-15, Ambulation in a wheel chair extensive assistance of 1 staff member, eating now requires supervision and set up help, Hygiene supervision and set up help of 1 staff member, occasionally incontinent of bladder

Review of these documents reveals significant changes in , transferring, ambulation, hygiene, eating, and incontinence, between the assessments, without a significant change assessment being completed within 14 days after the 6-3-15 or 12-2-15 assessments.

On 1-12-16 at 12 noon, Resident #3 was interviewed and stated that her functional status had significantly improved since admission.

On 1-12-16 at 5:00 p.m. the MDS RN coordinator responsible for MDS documentation in the facility was made aware of the need for significant change assessments. She stated that she needed to look more closely at the changes between assessments and would begin to develop a plan to implement for that.

On 1-12-16, and 1-13-16 at the end of the day debriefs, the Administrator and DON (director of nursing) were notified of findings, and no further documentation was available to be presented

2. Resident #8 was originally admitted to the facility on 3-11-15. Diagnoses included; Stroke (CVA), dysphagia with gastrostomy tube, aspiration pneumonia, dementia, hypertension, and diabetes.

Resident #8's most recent Minimum Data Set

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(MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 12-2-15. The Resident was coded with a Brief interview for mental status (BIMS) score of 10 points scored in a possible 15 points, indicating mild to moderate cognitive impairment. The Resident was coded as requiring limited assistance of 1 staff member for ambulation in a wheel chair, and eating. The Resident was also frequently incontinent of bladder.

The Most recent Full MDS assessment used for comparison, was an full admission Assessment completed on 3-18-15. The quarterly assessments between the most recent quarterly, and the full assessment were dated 6-8-15, and 9-2-15. All 4 assessments were reviewed for continuity of assessment correctness, as the most recent quarterly assessment, and the full admission assessment had numerous variations in functional ability. The comparisons follow.

The 3-18-15 full admission assessment to the 6-8-15 quarterly assessment revealed the following changes;

3-18-15, BIMS (brief interview for mental status) cognitive score of 5 of a possible 15 points indicating severe cognitive impairment, ambulation total dependence on 1 staff member, bathing total dependence on 2 staff members, and always incontinent of bowels.

6-8-15, BIM's (brief interview for mental status) cognitive score of 12 of a possible 15 points indicating mild cognitive impairment, ambulation extensive assist on 1 staff member, bathing extensive assist on 1 staff member, and always incontinent of bowels.

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The 9-2-15 quarterly assessment to the 12-2-15 quarterly assessment revealed the following changes;

9-2-15, BIM's score of 13 of 15 indicating mild cognitive deficit, Ambulation in a wheel chair extensive assistance of 1 staff member, eating completely dependent on 1 staff member, and frequently incontinent of bladder.

12-2-15, BIM's score of 10 of 15 indicating moderate cognitive impairment, Ambulation in a wheel chair limited assistance of 1 staff member, eating limited assistance of 1 staff member, and frequently incontinent of bladder

Review of these documents reveals significant changes in, cognition, ambulation, bathing, eating, and incontinence, between the assessments, without a significant change assessment being completed within 14 days after the 6-3-15, 9-2-15, or 12-2-15 assessments.

On 1-12-16 at 5:00 p.m. the MDS RN coordinator responsible for MDS documentation in the facility was made aware of the need for significant change assessments. She stated that she needed to look more closely at the changes between the assessments and would begin to develop a plan to implement for that.

On 1-12-16, and 1-13-16 at the end of the day debriefs, the Administrator and DON (director of nursing) were notified of findings, and no further documentation was available to be presented

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

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

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review and clinical record review the facility staff failed for one resident (Resident #13) of 15 residents in the survey sample to assess the resident after a change in condition and prior to pain medication administration.

On 10/5/15, Resident #13 was initially assessed by the nurse to be pain free. By mid morning, the resident complained of leg pain. The nurse administered pain medication without completing an assessment. Around 2:30 p.m., the resident was assessed to have a suspected leg fracture and sent to the hospital.

The findings included:

Resident #13, a 93 year old, was admitted to the facility on 3/3/12. Her diagnoses included femur fracture, cellulitis and dementia.

Resident #13's quarterly Minimum Data Set assessment with an Assessment Reference Date of 8/6/15 coded the resident with a Brief Interview of Mental Status score of 3. This indicated severe cognitive impairment. Extensive assistance was required with activities of daily

F 309 1. There was only one resident affected by the deficient practice. This resident has expired.

2. All Nursing Center residents with a complaint of pain have the potential to be affected. An audit of current residents using PRN pain medication more than 3 times per week over the past 30 days will be conducted to ensure that the treatment plan is effective and meeting the resident's goals for pain management. Physician will be contacted as needed for additional orders.
3. A new Pain Assessment Form will be implemented and the pain policy revised. All nursing staff will be educated on the importance of completing a thorough pain assessment with any complaint of pain.
4. Utilizing the nursing supervisor's report and monitoring the MARs for pain scores, chart audits will be done to insure that a pain assessment is documented in the chart for resident's experiencing complaints of pain. A total of 6 charts will be audited monthly for 3 months by the Interdisciplinary team. Findings from the monthly audits will be

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F 309	Continued From page 7 living. Resident #13's Medication Administration Record (MAR) included a section for pain monitoring. The MAR read "monitor pain every shift." The pain scale was defined as "1-3 mild pain, 4-6 moderate pain, 7-10 severe pain." On 10/5/15, the 7:00-15:00 (3:00 p.m.) shift pain assessment was documented as "0". At the end of day meeting on 1/12/16, the Director of Nursing (DON) was asked how the nurses were supposed to document pain during their shift. She stated that the nurse would complete their charting at the end of the shift, documenting pain if it had occurred during the shift. On 1/13/16 at 10:05 a.m., the DON corrected her statement about pain assessment. She stated that the nurses actually assessed pain at the beginning of the shift and the pain documented on the MAR was the pain assessment completed at the beginning of the shift. On 1/13/16 at the end of day meeting, the Administrator also stated that the nurse assessed pain at the beginning of the shift and this assessment was used to complete the pain assessment on the MAR. According to the MAR, on 10/5/15, it was documented that Resident #13 was pain free at the beginning of the morning shift which began at 7:00 a.m. A statement was taken from Resident #13's Certified Nursing Assistant (CNA) as a result of the fracture identified later in the day. The CNA's statement read "at 8:30 to 9:00 AM _____ was complaining about pain on her right leg I notice to the nurse this happening and after lunch I take her to bed and change her brief and I	F 309	4. (continued) analyzed for trends/patterns by the DON and reported to the QA Committee for additional oversight and recommendations. 5. Education will be provided to all staff by February 23, 2016	

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see her right leg was swollen and I call the nurse too see this".

The investigation statement from the nurse, Licensed Practical Nurse A (LPN A), was reviewed. The statement read "10/5/15 Resident up in w/c (wheelchair) fully dressed with CNA this AM. Resident propelling self in w/c smiling, CNA stated 'that resident is having some leg pain' Tramadol routine given and resident took all meds. After lunch CNA came and stated 'can you come look at _____ R (right) leg--I then came to her room and noticed her laying in bed and R leg looked twisted. Called to MD (doctor) and wound Dr. looked at leg and called daughter also--MD stated call 911 + sent out."

LPN A's nursing note for 10/5/15 was reviewed. The note read "10/5/15 8:30 p.m. <late entry for 1430 (2:30 p m.)> Resident awake + smiling; c/o (complaint of) pain in leg, Tramadol 1 tab given and no further pain resident propelling self in halls. took all meds. CNA called this writer to see resident's R leg, swollen and twisted CNA, nurse, supervisors and wound Dr. in room; wound Dr. evaluated and stated resident needs to go out for evaluation, no falls today, Dr.____ and daughter updated."

Resident #13's physician orders were signed on 10/2/15. Included were orders for three pain medications. Two medications were scheduled and one was to be given as needed. The orders read:
1. Acetamenophen 325 mg (milligram) give 2 tablets by oral route 3 times per day (10:00 am, 4:00 pm, 10:00 pm) Diagnosis- generalized leg pain

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2. Tramadol 50 mg (milligram) give 0.5 tablet (25 mg) by oral route once daily (10:00 am)
Diagnosis- pain in limb
Tramadol is a pain medication used to treat moderate to severe pain.
<http://www.webmd.com/drugs/2/drug-4398-5239/tramadol-oral/tramadol-oral/details>

3. Roxanol 5 mg every 4 hours as needed for severe pain scale 7-10
Roxanol is a form of liquid Morphine It is considered a short acting pain medication used to treat severe pain.
<http://www.webmd.com/drugs/2/drug-9480/roxanol-oral/details>

The acetamenophen and tramadol were documented as having been administered at 10:00 a.m. on 10/5/15.

LPN A was interviewed on 1/13/16 at 11:00 a.m. LPN (Licensed Practical Nurse) A stated that she remembers that the CNA told her that Resident #13 was in pain around 9:30 a.m. LPN A stated that she administered tramadol. When asked if she examined the resident's leg, she stated that she had not. LPN A stated that she did not notice signs of pain or crying at the time she gave the tramadol. She stated that she looked at the leg after lunch upon notification from the CNA. LPN A stated that the leg looked twisted.

Included in the facility investigation was a form "Coaching for Improvement" labeled with LPN A's name and was completed by the DON. "Presenting the problem" read "The nurse did medicate the resident at that time with her routine

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F 309	Continued From page 10 pain medication but failed to do an assessment of the R leg." The "Employers expectations" section read "Any resident who has a complaint of pain should have a thorough pain assessment performed." The Administrator and DON (Director of Nursing) were notified of the issue at the end of day meeting on 1/13/16.	F 309		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities, and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to store, prepare, and serve food in a sanitary manner. The 7 issues identified in the kitchen included: 1) A large case of raw shell eggs which were not pasteurized and were being used for all purposes for residents were available for use with no pasteurized eggs available. 2) 3 bags of an unknown dry food substance was located on a shelving unit, open and not labeled as to content or open date and were available for	F 371		

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F 371	Continued From page 11 use. 3) 1 bag of brown sugar was open to air on the shelving unit with no open date and was available for use. 4) Plastic food containers were nested within each other, wet, and not allowed to air dry. 5) Sausage and bacon were below holding temp on the breakfast serving tray line when temperatures were taken, and were not re-temped after they were reheated. 6) The high temperature dishwasher for all serving utensils and dinner ware, (plates, saucers, cups, etc) did not reach the required 150-165 degrees F for the wash cycle and 180 degrees for the rinse and sanitization cycle. The Dining Services Director and Executive Chef prepared 180 degrees for sanitization, during the wash or rinse cycles. 7) 5 different temperature log documents for the dish washer, refrigerators and freezers were documented 1-11-16, before 2:30 p.m. with temperatures for the 1-11-16 6:00 p.m. checks. The findings included: On 1-11-16 at 1:45 p.m., an initial tour of the main kitchen was conducted with the Dining Services Director and the Executive Chef. The observations made were as follows: 1) A large case of raw shell eggs, which were not pasteurized, and were being used for all residents, and all purposes according to the Executive chef, to include poached, and fried eggs. These raw eggs were available for use with no pasteurized eggs available, and were located in a walk in refrigerator. The Executive Chef stated they had been having trouble for a couple of months getting pasteurized eggs from	F 371	1. Each of the seven issues identified in the kitchen have been corrected. a. Unpasteurized eggs are no longer used. b. The 3 bags of unknown dry food were discarded. c. The open bag of brown sugar was discarded. d. The stacked wet containers were rewashed and dried. e. The sanitation process of the dishwasher has been switched to a chemical base. f. Any food item that does not meet adequate temperatures will be reheated. 2. All residents had the potential to be affected by the same deficient practice. There have been no reports of adverse resident outcomes.	

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F 371	Continued From page 12 their distributor, and were using these eggs instead. The executive Chef stated the eggs were being cooked until they were hard, before serving. 2) 3 bags of an unknown dry food substance was located on a shelving unit, open and not labeled as to content or open date and were available for use. The Dining Services Director discarded them when found by the surveyor. 3) 1 bag of brown sugar was open to air on the shelving unit with no open date and was available for use. The Dining Services Director discarded them when found by the surveyor. 4) Plastic food containers were nested within each other, wet, and not allowed to air dry. The Dining Services Director picked them up and took them to the dish washer to be rewashed when found by the surveyor. 5) The high temperature dishwasher for all serving utensils and dinner ware, (plates, saucers, cups, etc) did not reach the required 150-165 degrees F for the wash cycle and 180 degrees for the rinse and sanitization cycle. The Dining Services Director and Executive Chef prepared dishes to be loaded into the dishwasher to run a load of dishes through, so the surveyor could observe the temperatures of the cycles. The wash temperature was 147 degrees Fahrenheit (F), the required wash temp should have been 150-165 degrees F and the rinse temperature should have been 180 degrees F and was 156 degrees (F). The Executive Chef stated that if the dishwasher sat for awhile without use, it took a few runs to get to temperature. The Executive Chef was asked what temperature the	F 371	3. To ensure the deficient practices will not recur food safety training will be conducted for each dietary lead employee and supervisor. Training will include not using unpasteurized products, labeling and dating food products when opened, proper washing and drying of food containers and guidelines on proper temperature checks. Training will be conducted by Ecolab on proper chemical sanitation. 4.The Dining Services Director or Executive Chef will conduct weekly audits x 2 months in each of the above areas to ensure solutions are sustained. The weekly audits will be reported to the administration for tracking/ trending and results will be reported at Quarterly QA meetings. 5.Corrective action will be completed by 02/23/16	

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rinse cycle should reach. She stated 180 degrees, since they did not use chemicals, only high temperatures. The dishwasher was run three more times. Each time, the temperatures read lower than the initial trial. The Executive Chef was asked what they did with the dishes and silverware if the dishwasher did not reach the right temperature. She stated that they would call maintenance to fix the problem, and on the previous Friday (1-8-16) the maintenance department had worked on the dish washer, and it had started working properly. At this time they called maintenance to come and repair the dish washer.

The high temperature dishwasher for all serving utensils and dinner ware, (plates, saucers, cups, etc) did not reach the required 180 degrees for sanitization, during the wash or rinse cycles. The Dining Services Director and Executive Chef prepared dishes to be loaded into the dishwasher to run a load of dishes through, so the surveyor could observe the temperatures of the cycles. The wash temperature was 147 degrees Fahrenheit (F), the rinse temperature was 156 degrees (F). The Executive Chef stated that if the dishwasher sat for awhile without use, it took a few runs to get to temperature. The Executive Chef was asked what temperature the drying cycle should reach. She stated 180 degrees, since they did not use chemicals, only high temperatures. The dishwasher was run three more times. Each time, the temperatures read lower than the initial trial. The Executive Chef was asked what they did with the dishes and silverware if the dishwasher did not reach the right temperature. She stated that they would call maintenance to fix the problem, and on the previous Friday (1-8-16) the maintenance

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department had worked on the dish washer, and it had started working properly. At this time they called maintenance to come and repair the dish washer.

On 1-11-16 at 5:00 p.m., the dish washer was again observed, and was out of order, the staff had called their chemical company and was having chemical sanitization installed to by pass the need for high temp washing and rinsing.

On 1-12-16 at 7:30 a.m. breakfast tray line was observed. The dish washing machine was still not in working order.

On 1-12-16 at 5:00 p.m., the dishwasher was again observed operating now with the chemical sanitizer installed. The dishes were tested with chemical test strips for the proper sanitizing agent dilution amount.

On 1-13-16 at 11:00 a.m. The dish washer was again observed and were tested with chemical test strips for the proper sanitizing agent amount. The sanitizer was operating correctly at this time.

6) Temperature documents for checking the temperature of the dish washer, refrigerators and freezers were requested from the Executive Chef on 1-11-16 after initial tour. She supplied the documents at 2:30 p.m., and they were copied at that time. The documents revealed that all of the documents (5 total), had been documented on this day (1-11-16) before 2:30 p.m. when they were copied, with temperatures for the 1-11-16 6:00 p.m. checks. The original documents that the copies were made from were examined with the Dining Services Director, the Executive Chef, and the Administrator present in the conference

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room with 3 surveyors on 1-11-16 at 3:00 p.m.. The documents had "White out" liquid, to conceal the different time/temperature records, however, the hand written times and temperatures could still be seen through the "White out" areas and was acknowledged by all present. Those areas were as follows:

1-11-16 at 6:38 p.m. Dishwasher wash temp 155 degrees Fahrenheit (F), rinse temp 185 degrees Fahrenheit (F). The dishwasher would have been inoperable at this time.
1-11-16 at 6:25 p.m. Meat Cooler temp 36 degrees (F).
1-11-16 at 6:34 p.m. Produce Cooler temp 36 degrees (F).
1-11-16 at 6:30 p.m. Freezer temp 0 degrees (F).
1-11-16 at 6:38 p.m. Milk Cooler temp 36 degrees (F).

On 1-11-16 the employee responsible for documenting on these records (Employee H) was interviewed. He stated he was told to sign them, and so he did, however, he stated he did not document the times or temperatures, and could not say who did. The Dining Services Director, and Executive Chef also denied knowing who documented the times and temperatures.

7) On 1-12-16 at 7:30 a.m., breakfast tray line was observed by 2 surveyors. The food being served was checked for proper holding temperature prior to serving, by the Registered Dietician (RD) who was plating and serving the meal that morning. The sausage and bacon were below holding temp of 140 degrees (F). The sausage and bacon were temped at 132 degrees (F), on the breakfast serving tray line when temperatures were taken by the RD. The RD

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F 371	Continued From page 16 was asked what she was going to do with the below temp bacon and sausage, and her reply was "They have to be reheated". The Bacon and sausage which were in the same metal pan, were taken off of the serving line and reheated. The bacon and sausage were brought back to the serving line and placed in the steam table to be served. A list of facility infections was reviewed with the infection control nurse educator. There was no evidence of gastrointestinal outbreak at the facility. The Administrator, Dining Services Director, and the Executive Chef were notified of the kitchen issues on 1-11-16, 1-12-16 and 1-13-16 at the end of day debr efs. No further information was provided by the facility.	F 371		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to obtain physician ordered lab work timely for 1 resident (Resident #8) in the survey sample of 15 residents. For Resident #8, the facility staff failed to obtain a CBC (Complete Blood Count), and CMP (Complete Metabolic Profile) on 10-29-15, as	F 502		

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ordered by the physician.

The findings included:

Resident #8 was originally admitted to the facility on 3-11-15. Diagnoses included; Stroke (CVA), dysphagia with gastrostomy tube, aspiration pneumonia, dementia, hypertension, anticoagulant medication therapy, and diabetes.

Resident #8's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 12-2-15. The Resident was coded with a Brief Interview for mental status (BIMS) score of 10 points scored in a possible 15 points, indicating mild to moderate cognitive impairment. The Resident was coded as requiring limited assistance of 1 staff member for ambulation in a wheel chair, and eating. The Resident was also frequently incontinent of bladder.

A review of the Consultant pharmacist (RPH) "Consultation Report", dated 10-27-15 revealed a request from the RPH for a CBC at least annually (last completed 3-17-05), a Serum Creatinine at least every 6 months (last done 3-17-15), and monitoring for bleeding due to the administration of the Anticoagulant (blood thinner) Eliquis.

The physician agreed, and documented an order for lab work on the RPH "Consultation Report"dated 10-28-15, for Resident #8, who was to have a CBC, and CMP blood lab work obtained on 10-29-15, which was the next scheduled lab day.

Review of the clinical record revealed a lab report dated 11-4-15. The lab report documented the

1. The one resident affected did have the lab drawn on 11-4-15.
2. All residents that reside in the Nursing Center have the potential to be affected. Records of current residents will be reviewed for the past 2 months to ensure that all labs ordered have been obtained; any variances will be communicated to the physician for clarification.
3. Pharmacy recommendations are placed in each physician's folder for their review. The Nursing Supervisors on each shift will be responsible for checking each physician's folder daily for any signed recommendations and placing them on the chart to be transcribed.
4. An audit of the Physician's folders will be done once weekly for 3 months by the Interdisciplinary team. Variances will be investigated and corrected. The weekly audits will be monitored by trends/patterns by the DON/ designee and reported to the QA Committee for additional oversight or recommendation.

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

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Laboratory received the blood from the facility for testing of the CBC and CMP on 11-3-15. The CBC and CMP results were sent to the facility on 11-4-15, 6 days after the order was received on 10-28-15. There was no documentation found that the Doctor saw the lab results until 11-9-15, which the doctor signed 11-9-15 on the Alkaline Phosphatase result of the lab report from 11-4-15.

Resident #8's care plan was reviewed and stated obtain labs as ordered.

The facility "Documentation Guidelines" document was reviewed and stated for residents with diabetes labs must be properly documented. No documentation of labs being obtained or resulted existed in the nursing notes or in the clinical record. Only the physician's order, written on a pharmacy consultation report, and the lab result were found in the clinical record.

An interview was conducted with the day charge nurse RN (Registered Nurse) (D), Administrator and Director of Nursing (DON) on 1-12-16, at approximately 5:00 p.m. The Administrator stated that the lab was drawn on the next lab day after the order was obtained. The day charge nurse RN (D) stated that sometimes, the doctor would leave the pharmacy notes in a note book, and it could be 2 days before the nurses found the order to obtain the labs.

The facility administration was informed of the findings during end of day debrief on 1-12-16, and 1-13-16. The facility did not present any further information about the findings.