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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495019		C 07/21/2016

NAME OF PROVIDER OR SUPPLIER: WOODBINE REHABILITATION & HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 2729 KING ST, ALEXANDRIA, VA 22302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	**2016 STATE SURVEY PLAN OF CORRECTION**	
	An unannounced Medicare/Medicaid standard survey was conducted 07/19/16 through 07/21/16. Five complaints were investigated during this survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 307 certified bed facility was 259 at the time of the survey. The survey sample consisted of 27 current Resident reviews (Residents #1 through #27) and 7 closed record reviews (Residents #28 through #34).		Woodbine shares the state focus on the health, safety, and well-being of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, it has implemented its plan of correction to demonstrate its continuing efforts to provide quality care to its residents. The deficiencies cited by the surveyor will be put into the Continuing Quality Improvement/Quality Assurance and Process Improvement process and monitored through this system to assure compliance.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155	**F 155** **RIGHT TO REFUSE: FORMULATE ADVANCE DIRECTIVES** **Corrective Action:** DDNR forms identified during survey were reviewed for accuracy and completed appropriately after discussion with the RP, MD and interdisciplinary team. (Completed on 7/21/16) **Identification:** In order to ensure that no other residents were affected; a 100% audit will be conducted on DNR residents for accurate completion of the DDNR forms. Any forms found out of compliance will be reviewed with the resident, RP, MD and Interdisciplinary team and completed appropriately. (Completed by 8/31/16)	7/21/16 8/31/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 8/12/2016

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 155	Continued From page 1	F 155		

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and the Code of Virginia, it was determined that the facility staff failed to ensure a complete and accurate Durable Do Not Resuscitate (DDNR) for 2 of 34 Residents in the sample survey, Resident #18 and #7.

The Findings Included:

1. For Resident #18 the facility staff failed to ensure a complete and accurate Durable Do Not Resuscitate (DDNR).

Resident #18 was a 78 year old female who was admitted on 5/26/13. Admitting diagnoses included, but were not limited to: Alzheimer's, dementia, osteoporosis, anxiety and dysphasia.

The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 7/4/16. The facility staff coded that Resident #18 had short and long term memory impairment (1/1) and was moderately impaired (2) with daily decision making regarding Activities of Daily Living (ADL's).. The facility staff also coded that Resident #18 required extensive assistance (3/2) with ADL's.

On July 19, 2016 at 3:50 p.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced a Durable Do Not Resuscitate (DDNR). The DDNR was dated 5/28/13. Review of the DDNR sheet revealed that the DDNR was not accurate/complete. The DDNR had not documented whether Resident

Systemic Change:

The interdisciplinary team and Attending Physician will be re-educated on the proper completion of DDNR forms through in-servicing. (Completed by 8/31/16) 8/31/16

DDNR forms will be reviewed and discussed at each care plan meeting for accuracy and proper completion; it will be documented in care conference form note as well as in social services progress notes that the Code Status was reviewed and that the proper forms are in place.

Monitoring:

The director of social services or her designee will audit the 100% DDNR forms and new residents admitted weekly to ensure compliance. If any form was incorrectly completed, it will be reviewed with the interdisciplinary team, RP and attending MD and the form will be corrected. Any areas of non-compliance will be reported quarterly to QAPI team for discussion and further recommendations. (Completed by 8/31/16) 8/31/16

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F 155	Continued From page 2 #18 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment. Reference: Code of Virginia § 512.1-2987.1. Durable Do Not Resuscitate Orders. A. A Durable Do Not Resuscitate Order may be issued by a physician for his patient with whom he has a bona fide physician/patient relationship as defined in the guidelines of the Board of Medicine, and only with the consent of the patient or, if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the person authorized to consent on the patient's behalf. On July 19, 2016 at 3:55 p.m. the surveyor notified a Licensed Practical Nurse (LPN #6) and who was the Unit Manager, that Resident #18's DDNR was incorrect/inaccurate. The surveyor reviewed the clinical record with LPN #6. The surveyor reviewed the DDNR with the LPN (#6). The surveyor pointed out that the physician/facility staff had not determined whether Resident #1 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment. On July 20, 2016 at 2 p.m. the survey team met with the Administrator (Adm) and Director of Nurses (DON).The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure a complete and accurate DDNR for Resident #18. No additional information was provided prior to	F 155		

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F 155	Continued From page 3 exiting the facility as to why the facility staff failed to ensure a complete and accurate DDNR for Resident #18. 2. For Resident #7 the facility staff failed to ensure a completed DDNR (durable do not resuscitate) form. Resident #7 was admitted to the facility on 01/14/15 and readmitted on 01/20/15. Diagnoses included but not limited to hyperlipidemia, cerebrovascular accident, dementia, epilepsy, psychotic disorder, dysphagia, glaucoma, and hypertension. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/06/16 coded the Resident as 00 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #7's clinical record was reviewed on 07/19/16. It contained a physician's order dated 01/01/16 which read in part "Code status: DNR". The clinical record also contained a copy of the Virginia Department of Health DDNR form which read in part: " I further certify (must check 1 or 2): [] 1. The patient is CAPABLE of making an informed decision ... [] 2. The patient is INCAPABLE of making an informed decision ..... If you checked 2 above, check A, B, or C below: [] A. While capable of making an informed decision, the patient has executed a written advanced directive ..... [] B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a " Person	F 155		

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F 155	Continued From page 4 Authorized to Consent on the Patient ' s Behalf " ..... [] C. The patient has not executed a written advanced directive .... There were no checks in any of the boxes on the DDNR form. The section at the bottom of the DDNR form had been signed by the physician and the Resident's POA (power of attorney)." During a meeting with the administrative staff on 07/20/16 at approximately 1330 the incomplete DDNR form was brought to their attention. The DON (director of nursing) provided the surveyor with a completed copy of the DDNR form on 07/20/16 at approximately 1640. No further information was provided prior to exit.	F 155		
F 272 SS=D	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;	F 272	**F 272** **COMPREHENSIVE ASSESSMENT** **Corrective Action** The MDSs for residents #14 and #15 were modified by the MDS manager to reflect the dates of documentation in clinical record. (Completed on 7/20/16)	7/20/16

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F 272	Continued From page 5 Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; 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, the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) for 2 of 34 residents (Residents #14 and #15). The findings included: 1. The facility staff failed to document the dates of the documentation in Resident #14 ' s clinical record for Section V of the Care Area Assessment (CAA) Summary of the Minimum Data Set (MDS). Resident #14 was admitted to the facility on 2/10/16 with the following diagnoses of, but not	F 272	**Identification** In order to ensure that no other residents were affected, the MDS team will audit MDSs on the unit for the last quarter where residents #14 and #15 resides for documentation of dates in clinical record for section V of the CAA summary. Any areas of non-compliance will be reported to the MDS Manager for correction and the staff member that completed the MDS will receive re-education. (Completed by 8/31/16) **Systemic Change** Mandatory re-education will be conducted for MDS nurses for documentation of dates in clinical record for section V of the Care Area Assessments. The MDS team will audit 20% of the MDSs completed monthly. Any errors found will be reported to the MDS manager and will be corrected. The MDS manager will provide 1:1 counseling with the MDS nurse involved. (Completed by 8/31/16) **Monitoring** The MDS manager will audit 20% of completed MDSs. Any areas of non-compliance will be corrected and corrective action completed with the MDS nurse. A report of non-compliance will be submitted quarterly to the QAPI team for discussion and further recommendations. (Completed by 8/31/16/)	8/31/16 8/31/16 8/31/16

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limited to high blood pressure, diabetes, aphasia, anxiety, respiratory failure, dependent on ventilator, tracheostomy and gastrostomy. The admission MDS (an assessment protocol) with an ARD (Assessment Reference Date) of 2/17/16 coded the resident with a BIMS (Brief Interview Mental Status) of 3 out of a possible score of 15. Resident #14 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing.

The clinical record was reviewed by the surveyor on 7/19/16, at which time it was noted that on the MDS with ARD of 2/17/16, in Section V titled Care Area Summary (CAA) Summary, dates were not documented for Psychotropic Drug Use and Physical Restraints. The locations of these areas were noted to be documented in the above documented areas of the CAA Summary.

On 7/19/16 at the end of the day conference with the administrator, assistant administrator, director of nursing and assistant director of nursing were notified of the above documented findings in Resident #14 ' s clinical record.

On 7/20/16, the MDS Coordinator was interviewed in the conference room at approximately 6 pm. The MDS Coordinator stated to the surveyor that she was new and would have to " look better and make sure this doesn ' t happen again " . A sign in sheet was provided to the surveyor that documented education to the MDS staff of the CAA Location and Date Training that was conducted on 7/20/16. The surveyor was also given a copy of the corrected CAA Summary that had been corrected at the same time with the above documented training.

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F 272	Continued From page 7	F 272		

No further information was provided to the surveyor prior to the exit conference on 7/21/16.

2. The facility staff failed to document the dates of the documentation in Resident #15 ' s clinical record for Section V of the Care Area Assessment (CAA) Summary of the Minimum Data Set (MDS).

Resident #15 was readmitted to the facility on 5/17/16 with the following diagnoses of, but not limited to hemiplegia, seizure disorder, depression, respiratory failure, stroke, kidney failure, pressure ulcer, gastrostomy, and dysphagia. The admission MDS (an assessment protocol) with an ARD (Assessment Reference Date) of 5/24/16 coded the resident with short term and long term memory problems and severely impaired in decision making. Resident #15 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

The clinical record was reviewed by the surveyor on 7/20/16, at which time it was noted that on the MDS with ARD of 5/24/16, in Section V titled Care Area Summary (CAA) Summary, dates were not documented for Urinary Incontinence, Falls, Pressure Ulcer and Psychotropic Drug Use. The locations of these areas were noted to be documented in the above documented areas of the CAA Summary.

On 7/20/16 at the end of the day conference with the administrator, assistant administrator, director of nursing and assistant director of nursing were notified of the above documented findings in Resident #15 ' s clinical record.

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F 272	Continued From page 8	F 272		
	On 7/20/16, the MDS Coordinator was interviewed in the conference room at approximately 6 pm. The MDS Coordinator stated to the surveyor that she was new and would have to " look better and make sure this doesn ' t happen again " . A sign in sheet along with the information was provided to the surveyor that documented the education provided to the MDS staff of the CAA Location and Date Training that was conducted on 7/20/16. The surveyor was also given a copy of the corrected CAA Summary that had been corrected at the same time with the above documented training. No further information was provided to the surveyor prior to the exit conference on 7/21/16.			
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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review facility staff failed to provide services for the highest practicable well-being of 2 of 34 residents (Resident #22, and #21) ~ Coordination of dialysis services with facility staff for #22.	F 309	**F 309** **PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING.** **(1)** **Corrective Action** Immediate corrective action was taken by calling the dialysis center to complete their part of the form for resident #21 and resident # 22. The facility staff also completed the second portion of the form for both residents. (Completed on 7/21/16)	7/21/16

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F 309	Continued From page 9 ~ Orders regarding notifying the physician of Accucheck readings over 350 for #21. Findings: 1. Resident #22 was admitted to the facility on 7/18/14. The diagnoses included End Stage Renal Disease, hypertension, seizures, anxiety and depression. The resident's record was reviewed on 7/20/16 at 3:30 PM. The latest MDS (minimum data set assessment) dated 6/6/16 coded the resident with slight cognitive impairment. She required the assistance of staff members to accomplish all ADLs (activities of daily living.) The resident was continent of bowel and bladder. Under special treatments, she was coded for dialysis. The latest CCP (comprehensive care plan) was revised on 6/13/16. The plan included Dialysis treatment as a possible cause for infections, respiratory distress and edema. CCP interventions included observing the resident for s/s of infection, respiratory distress and edema. The dialysis site was to be checked for s/s of infection, irritation, and checked for bruit and thrill (graft/fistula.) Dialysis treatment as ordered. Resident #22 had physician's order for Dialysis on Mon, Wed, and Fri, at 11:30 AM at (name of a local dialysis facility.) The order was signed and dated by the physician on 7/19/14. The dialysis communication sheets used to share the flow of information between the facility and dialysis (three days a week) were reviewed from	F 309	**Identification** To identify other residents who may have been impacted by this practice a 100% audit of all dialysis residents will be conducted by unit managers to ensure that status reports documenting interchange of useful care information is sent with residents to and received from dialysis for each visit and all issues are addressed and report placed in resident's medical chart; any instance that proper communication was not documented, the nursing staff will contact the dialysis center to complete and the nurse will complete the facility information. (Completed by 8/31/16) **Systemic Change** Nursing staff will be in-serviced to ensure compliance with this process. A dialysis communication form will be initiated for each dialysis resident which will accompany residents to and from dialysis appointments for exchange of information, orders, recommendations and follow-ups. The facility nurse will complete the form by entering the vital signs of the resident prior to leaving the facility. The dialysis center will be expected to send a completed form back with the resident Vital signs and weights for pre and post dialysis and any other special instructions to care for the resident. If the dialysis center fails to do this, the unit manager or Nursing Supervisor will call the dialysis center to obtain the information needed. A 100% weekly audit of all dialysis residents will be conducted to validate completion of the form.	8/31/16

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F 309	Continued From page 10 8/7/15 through 7/18/16. These forms had a section for facility staff to fill out prior to transport to the dialysis center. This section included information on vital signs (blood pressure, pulse, respirations, temperature) and weight prior to transport. The dialysis section included the aforementioned vital signs and a pre- and post - weight for before and after dialysis. It also included the patient status and any pertinent messages from dialysis. Between 8/7/15 and 7/18/16 the surveyor observed a total of 59 communication sheets which were incomplete for either the facility information, the dialysis center or contained a date but no information from either party. The administrator and the DON were informed of these findings on 7/20/16 at 5:15 PM. They were asked to provide their contract with the dialysis center for surveyor preview. The Out-Patient Dialysis Services Agreement signed by both parties on 12/12/06 and 12/13/06 contained the following statement, "To maintain current clinical records of such services, and to provide such records to the nursing facility as needed." No additional info was provided prior to exit. 2. Resident #21 was admitted on 7/8/16. Her diagnoses included respiratory failure diabetes, chronic coronary artery disease and atrial fibrillation. Resident # 21's latest MDS (minimum data set) dated 7/15/16, coded the resident as unimpaired	F 309	Any discrepancies found will result in disciplinary action with staff involved. (Completed by 8/31/16) **Monitoring** The ADON or her designee will audit 20% of the completed dialysis transfer documents each month. Any non-compliance of dialysis communication forms will result in disciplinary action with staff involved. A report of non–compliance will be submitted to the Quarterly QA meeting for discussion. (Completed by 8/31/16) **(2)** **Corrective Action** The physician and responsible party for resident # 21 were notified about the error of administering wrong dose of insulin per sliding scale on 7/9/16 and 7/10/16. The physician was also informed of failure to notify him when the resident blood sugar read 353 at 11:30a.m on 7/10/16. No new orders were obtained and the resident did not experience any adverse consequences. The licensed nurses involved received 1:1 counselling and were re-educated on 7/22/16. (Completed by 7/22/16)	8/31/16 8/31/16 7/22/16

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F 309	Continued From page 11 cognitively. The MDS--as yet incomplete--did not note the resident's functional status. The interim care plan, dated 7/8/16, acknowledged the resident's diabetes under the problem of "nutrition." Interventions included monitor nutrition-related lab values and accuchecks. The admitting physician's orders, signed and dated 7/8/16, indicated sliding scale Novolog 100 unit/ml; amount : Per sliding scale: If blood sugar is less than 70, call MD. If blood sugar is O-150, give 0 units If blood sugar is 151 to 200, give 1 unit. If blood sugar is 201 to 250, give 2 units. If blood sugar is 251 to 300, give 3 units. If blood sugar is 301 to 350, give 4 units. If blood sugar is greater than 350, MD. subcutaneous Special instructions: Give Novolog per sliding scale. (Diagnosis: Type II diabetes mellitus without complications.) Before meals and at Bedtime; 07:30 AM, 11:30 AM, 04:30 PM, 09:00 PM. On 7/9/16 @ 11:30 AM, the accucheck was 223. No insulin was provided. On 7/9/16 @ 4:30 AM, the accucheck was 230. No insulin was provided. On 7/10/16 @ 11:30 AM, the accucheck was 353. 4 units of insulin were administered rather than the 5 units on the sliding scale orders. In addition to the aforementioned errors, the nursing staff had not called the physician to report Resident #21's accucheck on 7/10/16 at 11:30 AM was over 350 units.	F 309	**Identification** In order to ensure that no other residents were affected; MARS for residents residing on resident's # 21's unit for the last 30 days will be audited for accuracy. Any errors found will be reported to the physician and the nurses involved will receive counseling. (Completed by 8/31/16) **Systemic change** Mandatory in-servicing will be conducted for licensed nursing staff on obtaining blood sugars and administration of insulin per sliding scale with emphasis on administering the correct amount ordered by the physician and calling the physicians when blood sugar reading is above 350. (Completed by 8/31/16). **Monitoring** Nursing managers and supervisors will print administration records of residents receiving insulin per sliding scale for compliance and making sure physicians are called when readings are greater than 350. Any errors found will be corrected and physicians will be notified. Licensed staff will be disciplined if errors are found.	7/22/16 8/31/16

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	495019		C 07/21/2016

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F 309	Continued From page 12 The nursing progress notes were reviewed. No additional documentation could be found pertaining to the medication errors or the lack of notification to the physician. On 7/20/16 at 2:45 PM the director of nursing was informed of the surveyors findings. The administrator was informed at 5:15 PM the same day. No additional information was provided.	F 309	The ADON or her designee will check 10% of residents receiving insulin per sliding scale records weekly for compliance. Any areas of non-compliance will be subjected to corrective action. A report of non-compliance will be submitted to the quarterly QAPI meeting for discussion and further recommendations. (Completed by 8/31/16)	8/31/16
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F 329** **DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** **Corrective Action** The physicians for resident # 6, # 7, and #8 were notified of failure of staff to hold Metoprolol when the systolic blood pressure was less than 110 and pulse less than 60. Resident # 11's physicians were also informed of failure to hold Metoprolol when her systolic Blood pressure was less than 100 and pulse was greater than 100. (Completed on 7/20/16) **Identification** In order to ensure that no other residents were affected; of the units in which residents #6, #7, #8 and #11 reside medications which have blood pressure parameters will be audited for the last 30 days to ensure that all medications were given appropriately. Any areas of non-compliance, the attending physician will be notified and the nurse will receive corrective action. (Completed by 8/31/16)	7/20/16 8/31/16

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This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review it was determined that the facility staff failed to follow physician ordered drug parameters on 4 of 34 Residents in the sample survey, Resident #6, Resident #7, Resident #8 and Resident #11.

The Findings Included:

1. For Resident #6 the facility staff failed to follow physician ordered drug parameters on Metoprolol.

Resident #6 was a 71 year old female who was originally admitted on 8/5/15 and readmitted on 12/21/15. Admitting diagnoses included, but were not limited to: acute kidney failure, tracheostomy, asthma, pressure ulcer, depression, hypoglycemia, hypertension, dysphagia, pain disorder and a urinary tract infection.

The most current Minimum Data Set (MDS) assessment located in the electronic and paper clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 6/2/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #6 required extensive assistance (3/3) with Activities of Daily Living (ADL's).

On July 19, 2016 at 1 p.m. the surveyor reviewed Resident #6's electronic and paper clinical record. Review of the electronic and paper clinical record

Systemic Change

Mandatory in-services will be conducted for licensed nursing staff on following physician orders for blood pressure parameters. Unit managers will be tasked to print electronic administration records for residents on Metoprolol with Blood pressure parameters daily to validate if the medications were administered appropriately per physician orders. Errors found will be reported to the attending physicians and the nurses involved will receive corrective action.
(Completed by 8/31/16) 8/31/16

Monitoring

The ADON or her designee will conduct 10% audit on weekly basis. Any areas of non-compliance will be subjected to corrective action. A report of non-compliance will be submitted to the quarterly QAPI meeting for discussion and further recommendations.
(Completed by 8/31/16) 8/31/16

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produced signed physician orders dated 7/6/16. Signed physician orders included, but were not limited to the following order: "metoprolol tartrate tablet 25 mg; amt (amount): ½ tab (tablet) (12.5mg); oral Special Instructions: HOLD FOR SBP (systolic blood pressure) < (less than) 110, OR HEART RATE < 60 {DX (diagnosis): Secondary hypertension, unspecified} Every 12 Hours; 9 AM, 09:00 PM." (sic)

Continued review of the electronic and paper clinical record produced the July 2016 Medication Administration Records (MAR's). Review of the July 2016 MAR's revealed the following:

Resident #6's blood pressure was 100/52 on 7/4/16 at 9 p.m.
Resident #6's pulse/heart rate was 54 on 7/5/16 at 9 a.m.
Resident #6's blood pressure was 102/56 on 7/7/16 at 9 a.m.
Resident #6's blood pressure was 106/60 on 7/7/16 at 9 p.m.
Resident #6's blood pressure was 108/62 on 7/17/16 at 9 a.m.
Resident #6's blood pressure was 107/62 on 7/18/16 at 9 p.m.

The facility staff did not hold the Metoprolol for any of the blood pressures and pulse/heart rate on the above stated dates.

On July 19, 2016 at 2:55 p.m. the surveyor notified a Registered Nurse (RN #4) who was the Unit Manager (UM), that the facility staff had not followed the physician ordered Metoprolol parameters. The surveyor reviewed the electronic and paper clinical record with the UM. The surveyor pointed out the specific order for the

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F 329	Continued From page 15 Metoprolol and physician ordered parameters for the pulse and blood pressure. The surveyor then reviewed the July 2016 MAR's with the UM. The surveyor specifically pointed out that the Metoprolol was not held on 7/4/16, 7/5/16, 7/7/16, 7/17/16 and 7/18/16 when the blood pressure or pulse were less than 110 systolic or the pulse less that 60. On December 2, 2014 at 3:15 p.m. the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) that the facility staff failed to follow physician ordered medication parameters on Metoprolol. The surveyor notified the AT that the facility staff had not held the Metoprolol on 7/4/16, 7/5/16, 7/7/16, 7/17/16 and 7/18/16 when Resident #6's blood pressure was less than 10 or pulse was less than 60. No additional information was provided prior to exiting the facility as to why the facility staff failed to follow physician ordered medication parameters for Resident #6. 3. The facility staff failed to follow physician ordered blood pressure parameters for Resident #8. The facility staff administered Metoprolol 25 mg on 7/10/16 at 9:00 a.m. when the medication should have been held based on the physician ordered blood pressure parameters. The medication was to be held if the systolic blood pressure was less than 110. Resident #8's blood pressure was 106/55. The clinical record of Resident #8 was reviewed 7/19/16. Resident #8 was admitted to the facility 2/22/16 and readmitted 4/21/16 with diagnoses that included but not limited to respiratory failure, respirator dependent, tracheostomy, gastrostomy,	F 329		

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F 329	Continued From page 16 dysphagia, epilepsy, contractures both hands, enterocolitis due to Clostridium difficile, venous thrombosis and embolism, urinary tract infection, hypertension, persistent vegetative state, anxiety, constipation, neuronal ceroid lipofuscinosis, Vitamin D deficiency, and gastroesophageal reflux disease. Resident #8's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/28/16 assessed Resident #8 in a persistent vegetative state in Section B. The July 2016 physician orders were reviewed and included one for the administration of Metoprolol tartrate tablet; 25 mg; amt (amount): 1 tab (tablet); gastric tube Special Instructions: Dx (diagnosis)-HTN (hypertension) HOLD FOR SBP (systolic blood pressure) < (less than) 110 Every 12 hours; 09:00AM, 09:00PM. The surveyor reviewed the July 2016 electronic medication administration records (eMAR). The blood pressure recorded for 9:00 a.m. on 7/10/16 was 106/55. The medication box was initialed by "JO". Initialed medication boxes indicate medications are administered. The surveyor reviewed the 7/10/16 progress notes. The progress note for 7/10/16 at 3:31 p.m. did not include information concerning Resident #8's blood pressure. The vitals report for 7/10/16 was reviewed. The blood pressure documented prior to the administration of the 9:00 a.m. Metoprolol was 106/55 obtained at 7:37 a.m.--the same blood pressure reading on the eMAR. The surveyor discussed the above concern with the unit manager registered nurse #1 on 7/20/16	F 329		

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F 329	Continued From page 17 at 9:00 a.m. R.N. #1 reviewed the clinical record and informed the surveyor the nurse should have held the medication based on the physician orders. The surveyor informed the administrator, the assistant administrator, and the director of nursing of the above finding on 7/20/16 at 2:00 p.m. No further information was made available prior to the exit conference on 7/21/16. 4. The facility staff failed to follow physician ordered blood pressure parameters for the administration of the antihypertensive medication for Resident #11. The facility staff administered Metoprolol 12.5 mg on 7/4/16 at 6:00 p.m. The medication should have been held based on the physician ordered blood pressure parameters. The medication was ordered to be held if the systolic blood pressure was less than 100 and to be given if the heart rate was greater than 100. Resident #11's blood pressure was 99/51 at 6:00 p.m. The clinical record of Resident #11 was reviewed 7/20/16. Resident #11 was admitted to the facility 1/27/16 with diagnoses that included but not limited to respiratory failure, tracheostomy, gastrostomy, pneumonitis, severe sepsis with septic shock, hypotension, Down Syndrome, dysphagia, bilateral pneumonia, iron deficiency anemias, enterocolitis due to Clostridium difficile, ileus, candidiasis, urinary tract infection, gastroesophageal reflux disease, sacral pressure ulcer stage 4, right hip pressure ulcer stage 3, right heel pressure ulcer stage 1, Vitamin D deficiency, diabetes mellitus, seizure disorder,	F 329		

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chronic pain syndrome, secondary hypertension, and atrial fibrillation.

Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/28/16 assessed the resident with long and short term memory problems and severely impaired cognitive skills for daily decision making.

The July 2016 physician orders were reviewed and included one for the administration of Metoprolol tartrate tablet; 25 mg; amt (amount): 12.5 mg; gastric tube Special Instructions: GIVE FOR HR > (heart rate greater than) 100 HOLD FOR SBP < 100 [DX: Other secondary hypertension)] Every 12 hours; 06:00AM, 06:00PM.

The surveyor reviewed the July 2016 electronic medication administration records (eMAR). The blood pressure recorded for 6:00 p.m. on 7/4/16 was 99/51. The medication box was initialed by "RP". Initialed medication boxes indicate medications are administered. The surveyor reviewed the 7/4/16 progress notes. The progress notes for 7/4/16 at 4:08 p.m. and 10:33 p.m. did not include information concerning Resident 11's blood pressure. The vitals report for 7/4/16 was reviewed. The blood pressure documented prior to the administration of the 6:00 p.m. Metoprolol was 99/51 on the vitals report on 7/4/16 3:30 p.m. and the heart rate was 106.

The surveyor discussed the above concern with the unit manager registered nurse #1 and licensed practical nurse #1 on 7/20/16 at 4:00 pm. R.N. #1 reviewed the clinical record and informed the surveyor the nurse should have held

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the medication based on the physician orders. L.P.N. #1 stated it was a holiday weekend.

The surveyor informed the administrator, the assistant administrator, and the director of nursing of the above finding on 7/20/16 at 2:00 p.m.

No further information was made available prior to the exit conference on 7/21/16.
2. For Resident #7 the facility staff failed to follow physician ordered parameters for the administration of the anti-hypertensive medication atenolol.

Resident #7 was admitted to the facility on 01/14/15 and readmitted on 01/20/15. Diagnoses included but not limited to hyperlipidemia, cerebrovascular accident, dementia, epilepsy, psychotic disorder, dysphagia, glaucoma, and hypertension.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/06/16 coded the Resident as 00 of 15 in section C, cognitive patterns. This is a quarterly MDS.

Resident #7's clinical record was reviewed on 07/19/16. It contained a physician's order dated 01/01/16 which read in part "atenolol tablet; 25mg;amt: 1 tab; oral Special instructions: HOLD FOR SYSTOLIC BLOOD PRESSURE LESS HAN 110 AND HEART RATE LESS THAN 60 Once A Day; 08:00 AM"

Resident #7's MAR (medication administration record) was reviewed and contained the following entry which read in part "atenolol tab 25mg once a day hold for systolic blood pressure less

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F 329	Continued From page 20 than110 and heart rate less than 60". The entry for 07/17/16 was signed as having been administered with a notation in the comments sections which read in part "07/17/16 12:21 PM Late administration: Charted late Comment: On time. The recorded heart rate for this entry was listed as 58. The surveyor spoke with the unit manager regarding whether or not the medication should have been administered and the unit manager stated that the medication should have been held per the physician's orders. During a meeting with the administrative staff on 07/20/16 at approximately 1330 the concern of not holding the medication was brought to their attention. No further information was provided prior to exit.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility failed to ensure 1 of 34 residents was free of a significant medication error. (Resident 21.) Findings: Resident #21 was admitted on 7/8/16. Her diagnoses included respiratory failure diabetes, chronic coronary artery disease and atrial fibrillation.	F 333	**F 333** **RESIDENTS FREE OF SIGNIFICANT MED ERRORS** **Corrective Action** The attending physician and responsible party for resident # 21 were notified about the error of administering wrong dose of insulin per the sliding scale on 7/9/16 at 11:30a.m., 4:30p.m. and on 7/10/16 @11:30a.m. The attending physician was also informed that on 7/10/16 the licensed staff failed to inform him that the resident blood sugar reading was 353 at 11:30 a.m. No new orders were received. The nurses that were involved in these errors received 1:1 counseling. (Completed on 7/21/16)	7/21/16

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F 333	Continued From page 21 Resident # 4's latest MDS (minimum data set) dated 7/15/16, coded the resident as unimpaired cognitively. The MDS--as yet incomplete--did not note the resident's functional status. The interim care plan, dated 7/8/16, acknowledged the resident's diabetes under the problem of "nutrition." Interventions included monitor nutrition-related lab values and accuchecks. The admitting physician's orders, signed and dated 7/8/16, indicated sliding scale Novolog 100 unit/ml; amount : Per sliding scale: If blood sugar is less than 70, call MD. If blood sugar is O-150, give 0 units If blood sugar is 151 to 200, give 1 unit. If blood sugar is 201 to 250, give 2 units. If blood sugar is 251 to 300, give 3 units. If blood sugar is 301 to 350, give 4 units. If blood sugar is greater than 350, MD. subcutaneous Special instructions: Give Novolog per sliding scale. (Diagnosis: Type II diabetes mellitus without complications.) Before meals and at Bedtime; 07:30 AM, 11:30 AM, 04:30 PM, 09:00 PM. On 7/9/16 @ 11:30 AM, the accucheck was 223. No insulin was provided. On 7/9/16 @ 4:30 AM, the accucheck was 230. No insulin was provided. On 7/10/16 @ 11:30 AM, the accucheck was 353. 4 units of insulin were administered rather than the 5 units on the sliding scale orders. In addition to the aforementioned errors, the nursing staff had not called the physician to report Resident #21's accucheck on 7/10/16 at 11:30	F 333	**Identification** To ensure no other residents were affect a 100% audit will be conducted on residents who receive insulin per sliding scale on the unit where Resident # 21 resides. The attending physician will be notified of medications that were given outside the prescribed parameters and the nurses involved will receive 1:1 counseling. (Completed by 8/31/16) **Systemic Change** Licensed staffs will be in-serviced on obtaining blood sugars and administration of insulin per sliding scale with emphasis on administering correct dosage ordered by physicians. Unit managers will print insulin administration records daily to ensure that correct dosages are being administered per ordered sliding scale. (Completed by 8/31/16) ADON or designee will audit 20% of resident's on insulin per sliding scale weekly. Any areas of non-compliance will be subject to corrective action and any areas of non-compliance will be reported to the Quarterly QAPI meeting for discussion and further recommendations. (Completed by 8/31/16)	8/31/16 8/31/16 8/31/16

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F 333	Continued From page 22 AM was over 350 units. The nursing progress notes were reviewed. No additional documentation could be found pertaining to the medication errors or the lack of notification to the physician. On 7/20/16 at 2:45 PM the director of nursing was informed of the surveyors findings. The administrator was informed at 5:15 PM the same day. No additional information was provided.	F 333		
F 371 SS=E	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	F 371	**F 371** **FOOD PROCURE** **STORE/PREPARE/SERVE-SANTARY** **Corrective action** The staff members that were responsible to take and document food temperatures received correction action for failure to document at each meal time. (Completed by 7/22/16)	7/22/16
	This REQUIREMENT is not met as evidenced by: Based upon staff interview and facility document review, the facility staff failed to document tray line temperatures for each meal in the facility kitchen. The findings included: Upon review of documentation of the facility kitchen on 7/20/16, it was noted by the surveyor		**Identification** All residents receiving food from the kitchen may have been impacted. As a result, the staff members were observed during meal times for proper documentation of food temperatures by dietary manager to ensure proper procedures were followed. Dietary staff members were re-educated on proper monitoring of food temperatures and documentation of the temperatures. (Completed on 7/27/16)	7/27/16

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that the tray line temperatures for the following dates were left blank: 7/19/16 dinner, 7/12/16 lunch, 6/5/16 dinner, 5/6/16 dinner, 5/12/16 dinner, 5/13/16 dinner, 5/24/16 lunch to 5/31/16 breakfast, 5/31/16 dinner to 4/9/16 breakfast, 4/10/16 lunch, 4/11/16 dinner, 4/14/16 dinner, 4/15/16 dinner, 4/18/16 dinner, 4/19/16 dinner, 4/22/16 dinner, 4/23/16 dinner,

The dietary manager was asked by the surveyor for a copy of the policy and procedure on obtaining and documenting tray line temperatures. A " Food Temperatures " policy was provided to the surveyor which stated the following: " The temperatures of the food items will be taken and properly recorded for each meal. "

The dietary manager was notified of the above documented findings on 7/21/16 at approximately 8 am in the conference room. The surveyor asked what the expectation of the staff was in regards to obtaining and documenting tray line temperatures. The dietary manager stated " The staff knows they are supposed to write the temperatures down each time they are taken. "

The administrator, assistant administrator, director of nursing and assistant director of nursing was notified of the above documented findings on 7/21/16 at 9:45 am in the conference room.

No further information was provided to the surveyor prior to the exit conference on 7/21/16.

F 371

Systemic change

Dietary cooks and supervisors were re-educated on proper monitoring and documentation of food temperatures.
(Completed on 7/28/16) — 7/28/16

An updated form will be developed to clearly indicate temperatures to document with sign off of cook and supervisor.
(Completed by 8/31/16) — 8/31/16

The dietary manager or her designee will complete a daily audit of the food temperatures. Any areas of non-compliance will be immediately corrected and the staff member responsible for taking the temperatures will receive corrective action.
(Completed 8/31/16) — 8/31/16

Monitoring

To ensure compliance the dietary manager will audit the food temperature logs on a weekly basis. Copies of the food temp log will be submitted to the Assistant Administrator monthly. Any areas of non-compliance will be subject to immediate corrective action. The dietary manager will submit a report of non-compliance quarterly to the QAPI team for discussion and further recommendations.
(Completed by 8/31/16) — 8/31/16

F 428 SS=D 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

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The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review it was determined that the facility staff failed ensure that the pharmacy staff completed monthly Drug Regimen Reviews (DRR's) for 1 of 34 Residents in the sample survey, Resident #6.

The Findings Included:

For Resident #6 the facility staff failed to ensure that monthly Drug Regimen Reviews (DRR's) were completed. Review of the electric and paper clinical record did not produce a November 2015 DRR.

Resident #6 was a 71 year old female who was originally admitted on 8/5/15 and readmitted on 12/21/15. Admitting diagnoses included, but were not limited to: acute kidney failure, tracheotomy, asthma, pressure ulcer, depression, hypoglycemia, hypertension, dysphasia, pain disorder and a urinary tract infection.

The most current Minimum Data Set (MDS) assessment located in the electronic and paper clinical record was a Quarterly MDS assessment

F 428
DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

Corrective Action

Corrective action was taken immediately by notifying the pharmacist of the missing review in November. Upon clinical review, the pharmacist did complete the pharmacy review for December with no further recommendations. The resident did not have any adverse consequences. The attending physician was notified.
(Completed on 7/20/16) — 7/20/16

Identification

To identify that no other residents were affected; a 100% audit will be conducted to ensure that pharmacy reviews are being completed on all residents. Any areas of noncompliance will be reported to the pharmacist and attending physician for immediate review.
(Completed by 8/31/16) — 8/31/16

Systemic Change

Unit managers will re-educated on reviewing resident's electronic medical records to ensure the pharmacy consultants is completing the monthly drug review regimen on all residents to ensure completion.
(Completed by 8/31/16) — 8/31/16

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F 428	Continued From page 25 with an Assessment Reference Date (ARD) of 6/2/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #6 required extensive assistance (3/3) with Activities of Daily Living (ADL's). On July 19, 2016 at 1 p.m. the surveyor reviewed Resident #6's electronic and paper clinical record. Review of the electronic and paper clinical record produced monthly DRR's. Review of the electronic and paper failed to produce a DRR for November 2015. On July 19, 2016 at 2:55 p.m. the surveyor notified a Registered Nurse (RN #4) who was the Unit Manager (UM), that the pharmacy had not completed a November 2015 DRR on Resident #6. The surveyor reviewed the electronic and paper clinical record with the UM. The surveyor pointed out that the electronic and paper clinical record failed to produce the November 2015 DRR. The UM reviewed the electronic and paper clinical record and was unable to locate the November 2015 DRR. On July 19, 2016 at 3:30 p.m. the surveyor observed the Director of Nursing (DON) at the nurses ' desk. The surveyor notified the DON that Resident #6 did not have a November 2015 DRR. The DON reviewed the electronic and paper clinical record and was unable to locate the November 2015 DRR. On December 2, 2014 at 3:15 p.m. the survey team met with the Administrator (Adm) and DON. The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure that the pharmacy completed monthly DRR's for Resident	F 428	**Monitoring** ADON or designee will audit 20% of all residents electronic medical records monthly to ensure all pharmacy reviews are being conducted monthly. Any areas of non-compliance will be reported immediately to the pharmacist and attending physician and a report of non-compliance will be submitted quarterly at the QAPI meeting for discussion and further recommendations. (Completed by 8/31/16)	8/31/16

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F 428	Continued From page 26 #6. The surveyor notified the AT that a DRR was not completed for November 2015. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that the pharmacy completed monthly DRR's for Resident #6.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	**F 441** **INFECTION CONTROLPREVENT SPREAD LINENS** **Corrective Action** The Certified nursing assistant who was involved in this incident received 1:1 counseling and was re-educated on proper hand washing techniques. An apology was rendered to the resident #8. (Completed on 7/20/16) **Identification** To ensure that no other resident were affected by CNA # 1; C.N.A. # 1 was re-educated and observed for competency with performing perineal care and hand washing. (Completed by 8/15/16) **Systemic Change** Nursing supervisors and unit managers will observe ten certified nursing assistants during perineal care with focus on proper handwashing technique. Any certified nursing assistant observed not in compliance will receive corrective action. (Completed by 8/31/16)	7/20/16 8/15/16 8/31/16

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F 441	Continued From page 27 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control guidelines for glove removal and hand washing for 1 of 34 residents (Resident #8). The findings included: The facility staff failed to wash hands after removing one layer of gloves after providing perineal care to Resident #8. Certified nursing assistant #1 (C.N.A. #1) had a second pair of disposable gloves on and applied perineal cream (Inzo cream) to Resident #8's buttocks without removing the second layer of gloves and washing her hands. The clinical record of Resident #8 was reviewed 7/19/16. Resident #8 was admitted to the facility 2/22/16 and readmitted 4/21/16 with diagnoses that included but not limited to respiratory failure, respirator dependent, tracheostomy, gastrostomy, dysphagia, epilepsy, contractures both hands, enterocolitis due to Clostridium difficile, venous thrombosis and embolism, urinary tract infection, hypertension, persistent vegetative state, anxiety, constipation, neuronal ceroid lipofuscinosis, Vitamin D deficiency, and gastroesophageal	F 441	**Monitoring** The infection control nurse will observe ten certified nursing assistant for perineal care monthly with focus on handwashing. Any areas of non-compliance will be corrected immediately and the individual will be subjected to corrective action. A report of non-compliance will be submitted quarterly to the QAPI team for discussion and further recommendations. (Completed by 8/31/16)	8/31/16

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F 441	Continued From page 28 reflux disease.	F 441		

Resident #8's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/28/16 assessed Resident #8 in a persistent vegetative state in Section B.

The surveyor entered Resident #8 ' s room on 7/19/16 at 1:55 p.m. Two certified nursing assistants (C.N.A. #1 and C.N.A. #2) were providing ADL (activities of daily living) care to Resident #8. Resident #8 was turned to her left side and C.N.A. #1 was providing incontinence care. Resident #8 was observed to be incontinent of bowel. Upon completion of the incontinence care, C.N.A. #1 removed her gloves. The surveyor noted a second pair of gloves on C.N.A. #1's hands. C.N.A. #1 stated she always double-gloved. She stated there may be holes in the gloves or tears. C.N.A. #1 then applied Resident #8's barrier cream to the buttocks. C.N.A. #1 removed the second pair of gloves and washed her hands.

The surveyor discussed the concern with licensed practical nurse #1 on 7/201/6 at 9:00 a.m. L.P.N. #1 stated that practice was "frowned upon." She stated "The C.N.A. should have taken the gloves off, both pairs, cleaned her hands, donned new gloves and applied the ointment. We are currently doing competencies for perineal care."

The surveyor requested the C.N.A. #1's perineal competency and the facility policy on glove removal and hand washing.

The surveyor reviewed the facility policies titled "Handwashing/Sanitizing and Infection Control"

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F 441	Continued From page 29 on 7/20/16 at 1:05 p.m. The policy for handwashing/sanitizing read in part under procedure "2. Examples of when to wash hands. This is not intended to be an all-inclusive list: b. Before putting on gloves and after removing gloves." The Infection Control policy read in part "9. Standard Precautions e. Use of gloves when providing care to the resident. ii Wear gloves that fit. iii Wear disposable gloves for providing direct resident care. iv Remove gloves after contact with the individual resident and clean hands per facility protocol. v. Change gloves during care if hands move from a contaminated site to a clean body site." The surveyor informed the administrator, the assistant administrator, and the director of nursing of the infection control concern during the end of the day meeting on 7/20/16 at 2:00 p.m. The surveyor interviewed the infection control nurse registered nurse #2 on 7/21/16 at 9:10 a.m. R.N. #2 stated perineal competencies started in May 2016. C.N.A. #1's most recent competency for perineal care was 7/22/13. R.N. #2 stated double gloving should not be done but to remove gloves and wash hands. No further information was provided prior to the exit conference on 7/21/16.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514	**F514** **RECORDS-COMPLETE/ACCURATE/ACCESSIBLE** **Corrective Action**	

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F 514 Continued From page 30
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 staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 2 of 34 Residents, Residents #2 and #31.

The findings included.

1. For Resident #2, the facility staff documented in the clinical record on two different dates that the Resident had a restraint in place. The restraint had been discontinued.

Resident #2 had been admitted to the facility 04/22/15. Diagnoses included, but were not limited to, respiratory failure, dysphagia, hypertension, atrial fibrillation, diabetes, contracture, and aphasia.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/04/16 was coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. Section P (restraints) was coded to indicate the Resident did not use a restraint.

F 514

The licensed nurse who made the wrong entry in resident # 2's chart received 1:1 counseling. She apologized to the surveyor that she had made the entry in error. She corrected her note after she spoke with the Surveyor on 7/20/16.

The RN nursing supervisor who failed to document her findings for resident #31 received corrective action for failure to document findings on 7/23/16.
(Completed by 7/23/16) 7/23/16

Identification

To ensure that no other residents were affected by licensed nurse #3; a 100% review of the resident charts' that L.P.N. #3 cared for the last 30 days will be audited for errors by the Unit Manager. Any errors found will be reported to the DON and corrected if appropriate per nursing standard of practice.
(Completed by 8/31/16) 8/31/16

To ensure that no residents were affected, all expired residents in the last 30 days, clinical records will be audited for complete documentation of findings by the RN.
(Completed by 8/31/16) 8/31/16

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F 514	Continued From page 31	F 514		
	The Residents clinical record included a signed consent for a restraint dated March 1, 2016.		**Systemic Change**	
	A review of the Residents current physician orders indicated that the Residents restraint (mitten on Resident's left hand to prevent them from pulling medical equipment out at all times) had been discontinued on 06/08/16.		Licensed staff will be re-educated on documenting accurately in residents clinical record. The unit manager on the unit where LPN # 3 works will audit her nurse's notes for errors on weekly basis, any errors found will be reported to the DON and LPN#3 will be informed and if there is no progress LPN #3 will face disciplinary action. (Completed by 8/31/2016)	8/31/16
	LPN (licensed practical nurse) #3 had documented on 06/17/16 at 3:09 p.m. that Resident #2 had "...Left hand mitten in place..." and on 07/19/16 "...Left hand mitten in place..."			
	On 07/20/16 at approximately 10:55 a.m. the surveyor interviewed LPN #3. After reading her notes LPN #3 verbalized to the surveyor that the Resident did not have a mitten in place and she had charted in error. On 07/20/16 at approximately 11:05 a.m. LPN #3 verbalized to the surveyor that they gave the Resident a wash cloth to hold and they had been told in stand up the restraint had been discontinued.		RN Supervisors will be re-educated on documenting their findings when residents are pronounced to have expired in the clinical record. The Unit Manager or designee will audit charts of residents who have expired daily to ensure that documentation is in place. If any documentation is found missing the RN will be notified to correct documentation and will receive 1:1 counseling. (Completed by 8/31/16)	8/31/16
	During observations of Resident #2 the Resident was observed with a wash cloth in his left hand.		**Monitoring**	
	The administrator and DON (director of nursing) were notified of the above in meeting with the survey team on 07/20/16 at approximately 1:55 p.m. During a second meeting with the survey team on 07/21/16 at approximately 9:45 a.m. the DON verbalized to the survey team that the restraint was removed from the room when it had been discontinued.		The ADON or her designee will audit 100% of clinical records of residents that have expired monthly in the facility. Any areas of non-compliance will be corrected immediately and the nurse subjected to corrective action. A report of non-compliance will be submitted to the QAPI team for discussion and further recommendations. (Completed by 8/31/16)	8/31/16
	No further information regarding this issue was provided to the survey team prior to the exit			

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F 514	Continued From page 32 conference. 2. The facility staff failed to maintain a complete and accurate clinical record for Resident #31. Resident #31 expired on 11/27/15. The registered nurse who pronounced Resident #31's death failed to document the findings in the clinical record. The clinical record of Resident #31 was reviewed 7/20/16 and 7/21/16. Resident #31 was admitted to the facility 6/15/15 and readmitted 11/20/15 with diagnoses that included acute respiratory failure, tracheostomy, gastrostomy, dysphagia, persistent vegetative state, hypertension, left knee contracture, anxiety, chronic pain, dyspnea, constipation, and gastroesophageal reflux disease. Resident #31's 30 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/12/15 assessed the resident in Section B as in a persistent vegetative state. During Resident #31's hospitalization 11/3/15 through 11/20/15, Resident #31 was compassionately weaned from the ventilator. When Resident #31 was readmitted to the facility 11/20/15, physician orders included orders for hospice consult. Resident #31 expired 11/27/15. The progress note dated 11/27/15 at 3:30 a.m. read "Resident was noted with no vital signs at 3:20am. Expired at 3.20 am. Supervisor (registered nurse #6) came in and resident was pronounced by supervisor. MD (medical doctor) was called and notified and order received to release body to funeral home of family's choice." Three other progress notes were written on 11/27/15 at 3:45 a.m., 4:30 a.m., and 6:00 a.m. All progress notes written 11/27/15 were by	F 514		

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F 514	Continued From page 33 licensed practical nurses. There was no documentation by the facility registered nurse or the hospice registered nurse when Resident #31 expired. The surveyor informed the director of nursing on 7/21/16 of the above lack of documentation concerning Resident #31's pronouncement of death by a registered nurse. The director of nursing provided the surveyor with the 24 hour report for 11/26/15. Written on the 11/26/15 24 hour report for the ventilator unit was the following written by registered nurse #6 for Resident #31 "Expired @ 3.20 a.m. Pronounced by me. No BP (blood pressure) no pulse no resp (respirations)." The surveyor informed the administrator, the assistant administrator, the director of nursing, and the director of clinical operations of the above concern in documentation on 7/21/16 at 9:45 a.m. No further information was provided prior to the exit conference on 7/21/16.	F 514		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	495019		07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBINE REHABILITATION & HEALTHCARE CEI	2729 KING ST ALEXANDRIA, VA 22302

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F 000	Initial Comments	F 000		
	An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 07/19/16 through 07/21/16. Five complaints were investigated during this survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 307 certified bed facility was 259 at the time of the survey. The survey sample consisted of 27 current Resident reviews (Residents #1 through #27) and 7 closed record reviews (Residents #28 through #34).			
F 001	Non Compliance	F 001		
	The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.			
	Physician Services 12 VAC 5-371-240 (D)-Cross reference to F tag 155		**Please cross reference F Tag 155 on Page 1 of POC**	
	Resident Assessment and Care Planning 12 VAC 5-371-250 (A)-Cross reference to F tag 272		**Please cross reference F Tag 272 on Page 5 of POC**	
	Nursing Services. 12 VAC 5-371-220 (B)-Cross reference to F tags-309, 329, and 333		**Please cross reference F Tag 309 (Pg. 9), 329 (Pg.13) and 333 (Pg. 21) on respective pages of the POC**	
	Dietary & Food Service program			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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F 001	Continued From Page 1	F 001		
	12 VAC 5-371-340-Cross reference to F tag 371		**Please cross reference F Tag 371 on Page 23 of POC**	
	Pharmaceutical Services 12 VAC 5-371-300 (D, H)-Cross reference to F tag 428		**Please cross reference F Tag 428 on Page 24 of POC**	
	Infection Control. 12 VAC 5-371-180 (C)-Cross reference to F tag 441		**Please cross reference F Tag 441 on Page 27 of POC**	
	Clinical Records. 12 VAC 5-371-360 (A, E.4)-Cross reference to F-514		**Please cross reference F Tag 514 on Page 30 of POC**	