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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted on 12/6/16 through 12/8/16. Complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 118 certified bed facility was 113 at the time of the survey. The survey sample consisted of 20 current resident reviews (Residents #1 through #20) and six closed record reviews (Residents #21 through # 26).	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or	F 225	1. Residents #4 & #5 continue to reside at the facility in stable condition. Both residents were assessed and records reviewed. No evidence of abuse, neglect or other injuries of unknown source were identified. 2. Records of current residents were reviewed by the Center Nurse Executive (CNE)/designee to determine any other injuries of unknown source. None were identified during this review.\ 3. Facility staff in all departments and on all shifts will be re-educated by the Center Executive Director (CED)/designee on the current regulations, requirements and policies specific to resident abuse, neglect, misappropriation	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	12-27-16

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 225	Continued From page 1 licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate	F 225	and injuries of unknown source. All new employees will receive this information as part of their initial orientation. 4. CNE/designee will conduct audits of resident records, as well as review documentation during standing clinical meetings, to determine compliance with all reporting requirements. Results of the audits and reviews will be shared at the monthly QA Committee meetings x3 months.	1/21/17

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corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to investigate and report an injury of unknown origin for two of 26 residents in the survey sample, Resident #4 and Resident #5.

1. The facility staff failed to investigate and report Resident #4's 5/4/16 fractured ankle of unknown injury to the required state agency.

2. The facility staff failed to report a fracture of unknown origin (right femoral neck) to the required state agency in a timely manner for Resident #5.

The findings include:

1. Resident #4 was admitted to the facility on 11/15/10 and readmitted on 1/3/11 with diagnoses that included but were not limited to: dementia, depression and anemia.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 11/28/16 coded the resident as being severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the nurse's notes dated 5/4/16 at 11:00 a.m. documented, "Type: Change in Condition. (Name of resident) is experiencing pain. L (left) ankle/grimacing and yelling when touched. L inner ankle noted to be discolored, L ankle is warm to touch, swollen and painful to touch." There was no documentation regarding how this

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injury occurred.

Review of the physician's orders dated 5/4/16 documented, "x ray L ankle -- r/o (rule out) fracture." Further review of the physician's orders for 5/4/16 documented, "SEND TO (name of hospital) ER (emergency room) TO EVAL (evaluate) + TREAT."

Review of the emergency room note dated 5/4/16 at 9:03 p.m. documented, "(Name of facility) is unsure how the injury happened. Pt (patient) had an x ray done today showing a tib (tibia) fib (fibula) fracture."

Review of the x-ray report dated 5/4/16 at 9:47 p.m. documented, "Impression: Fracture of distal left tibia."

A request was made on 12/8/16 at 9:30 a.m. to ASM (administrative staff member) #2, the nurse executive, for a copy of the facility reported incident (FRI) for Resident #4's 5/4/16 leg fracture of unknown origin. ASM #2 stated, "I brought all the FRIs in." There was no FRI for Resident #4. A request to review the investigation to the injury was made at that time.

An interview was conducted on 12/8/16 at 2:25 p.m. with ASM #2. When asked the process staff follows for an injury of unknown injury, ASM #2 stated, "When we have an incident, the nurse on that shift completes it (the incident report)." When asked what happened next, ASM #2 stated, "The next day we come in and investigate it." When asked to review the investigation for Resident #4's fracture of unknown origin, ASM #2 stated, "Because we had a diagnosis of osteopenia (1) I think it got me off the track and I didn't send it (a

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FRI) into the state."

Review of the facility's policy titled, "Abuse Prohibition" documented, "POLICY (Name of company) shall prohibit abuse, neglect, exploitation, involuntary seclusion, and misappropriation of property for resident through the following: ....Investigation of incidents and allegations... 5. Staff shall identify events -- such as suspicions bruising of residents -- occurrences, patterns, and trends that may constitute abuse, and determine the direction of the investigation. 6. Upon receiving information concerning a report of abuse, the CED (chief executive director) or designee shall: 6.1 Conduct an immediate and thorough investigation which shall focus on: 6.1.1 If abuse or neglect occurred and to what extent...6.2 The investigation shall be thoroughly documented on any state required form, and on the Incident/Accident Investigation. "

No further information was provided prior to exit.

(1) Osteopenia -- Osteopenia is a term to define bone density that is not normal but also not as low as osteoporosis. By definition from the World Health Organization osteopenia is defined by bone densitometry as a T score -1 to -2.5. There are many causes for osteopenia including calcium and vitamin D deficiency and inactivity. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/21234807/

2. The facility staff failed to report a fracture of unknown origin (right femoral neck) to the required state agency in a timely manner for Resident #5.

Resident #5 was admitted to the facility on

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3/2/2011 and readmitted on 9/9/16 with diagnoses that included but were not limited to type two diabetes, unspecified dementia without behavioral disturbance, muscle weakness, difficulty in walking, hypertension, osteoporosis, breast cancer, heart failure, and hypothyroidism.

Resident #5's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 11/22/16. Resident # 5 was coded as being cognitively impaired in the ability to make daily decisions scoring 07 out of 15 on the BIMS (brief interview for mental status) exam. Resident #5 was coded as requiring extensive assistance from two plus staff members with transfers, bed mobility, toileting, bathing, and locomotion off the unit.

Review of the physician's notes revealed the following note documented by the nurse practitioner on 11/8/16: "Chief complaint: C/O (complaint) pain in B/L (bilateral) legs. History of present illness: 83 y.o. (year old) Caucasian female, a LTC (Long Term Care) resident at (name of facility), hospitalized 9/5 to 9/9 with AMS (altered mental status) due to UTI (Urinary Tract infection) with sepsis, and worsening CHF (congestive heart failure). Since her readmission it is apparent that she has had a mental decline as she is more quiet in nature and was not able to answer questions as she has in the past. She is seen today for new reports of pain and management of DM (diabetes mellitus) and hypothyroidism... Diagnoses and Assessment: Res (resident) w/pain (with pain) in hips, pelvis and knees upon movement. Yells at the top of her lungs, will order x-rays. Res (Resident) is not asking for pain med (medication) prn (as needed) so will order celebrex (1) 100 mg (milligrams) po

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(by mouth) BID (twice a day) w/meals (with meals) and will start low dose fentanyl patch (2) of 12 mcg (micrograms)...Spoke with RP (responsible party) about above concerns, RP verbalized understanding and agrees with POC (Plan of Care)."

Review of Resident #5's physician verbal orders revealed the following order dated 11/8/16: "...3 Celebrex 100 mg 1 cap (capsule) po BID 8 AM and 5 PM with food...4. Fentanyl patch 12 mcg apply patch q72 hours (every 72 hours) for pain...5. X-ray of B/L hips and pelvis for pain...6. X-ray of bilateral knees."

Review of Resident #5's X-ray results revealed that the X-ray did not arrive to the facility until 11/9/16 (the following day). The radiology report documented the following: "Hips bilat (bilateral) W (with) pelvis 2 view...Results: Nondisplaced age-indeterminate fracture of the right femoral neck. No fracture of the left hip. Bilateral degenerative changes involving the hips..."

Review of the FRI (Facility Reported Incident) revealed that the fracture of unknown origin was not reported to the OLC (Office of Licensure and Certification) until 11/16/16 (6 (six) working days) after the fracture was discovered.

Review of the follow up report dated 11/21/16; revealed that the fracture was determined to be pathological in nature after the investigation was completed. The investigation was initiated on 11/18/16.

Review of the investigation revealed the following note dated 11/18/16 by a nurse who worked on 11/10/16 and 11/11/16 on the 3-11 shift: "I worked

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3-11 Nov 10 + 11 (Thur/Fri). Was told in report that XR (X-ray) was negative and that MRI (Magnetic Resonance Imaging) may be considered. No unusual indication c/o (complaints of) of pain verbalized or reported. Celebrex and Fentanyl patch were ordered 11/8 and were in effect when I worked Nov 10 and 11."

Further review of the investigation revealed a note dated 11/18/16 from the Nurse Practitioner. It documented the following: "She was assessed on 11/8/16 for c/o pain as reported by nursing. X-ray of B/L (Bilateral) hips and pelvis were ordered with physical assessment along with antiinflammatories and pain meds (medications).
11/9/16= X-rays were done and not received until p.m.
11/10/16= I was not in the building.
11/11/16- I followed up X-ray results (+) (positive) for (R) (right) femoral neck fracture. Continued pain med.
11/14/16- Able to contact RP (responsible party) and discussed results of X-ray and POC (Plan of Care) which included continued pain management and ortho (orthopedic) consult. She is NWB (Non Weight Bearing) at this time. Will await recommendations of ortho consultation, appt (appointment) has been made."

On 12/7/16 at 2:57 p.m., an interview was conducted with LPN (licensed practical nurse) #5, the nurse who worked on 11/10/16 and 11/11/16, on the 3-11 shift. When asked what she could recall about Resident #5's fracture, LPN #5 stated that she was not quite sure how her fracture occurred. When asked about the process staff follows if a resident's X-rays come back positive for a fracture, LPN #5 stated that she would call the NP for notification and to receive new orders,

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notify the family, and then chart orders that were received. LPN #5 stated that she would talk to staff to see if they know anything about how the resident could have obtained a fracture and notify administration immediately. LPN #5 stated that she was told in report that Resident #5's X-rays were negative on 11/10/16. LPN #5 stated that she did not personally look at the X-ray results because she was told in report that they were negative.

On 12/7/16 at 3:11 p.m., an interview was conducted with LPN #6, the nurse who faxed the orders for the X-rays. LPN #6 stated that she was called in to work part of 7-3 and 3-11 shifts on 11/8/16. LPN #5 stated she saw the orders flagged for the X-ray and pain medication, and she took the orders off and faxed them to pharmacy. LPN #6 also stated that she called for the X-ray and notified the family. LPN #6 stated that the X-ray was not ordered STAT (Immediate) and X-ray did not arrive on her shift. LPN #6 stated that if the situation is not an emergency, X-rays will not be ordered STAT. LPN #6 stated that if X-rays are not ordered STAT, they usually arrive to the facility the next day. LPN #6 worked until 11 p.m. that night. When asked the reason for the X-ray, LPN #6 stated that she was told the resident was complaining of increased pain and the NP assessed the resident before writing the order. When asked if Resident #5's positive X-ray results should have been reported to administration immediately, LPN #5 stated that Administration should be notified right away so they can start an investigation on how the fracture occurred.

On 12/8/16 at approximately 11:30 a.m., an interview was conducted with ASM (administrative

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staff member) #1, the administrator and ASM (administrative staff member) #2, the DON (Director of Nursing). When asked when an injury of unknown origin should be reported, ASM #2 stated, "Right Away." ASM 1 stated, "Within 24 hours." ASM #2 stated, "This was the delayed FRI (facility reported incident). I think what happened was the NP went to check on her (resident) for an unrelated situation and the resident was in a lot of pain at that time. She ordered X-rays of the bilateral hips and pelvis, and bilateral knees. Whoever the nurse was who looked at the X-rays, saw that one X-ray was negative and thought all X-rays were negative. She left them for NP to view when the NP arrived to facility (11/11/16)." ASM #2 stated that administration was not made aware of the fracture until 11/16/16 and they immediately reported this fracture to the state. ASM #2 stated that they concluded the fracture was pathological given her medical condition.

On 12/8/16 at approximately 1 p.m., an interview was conducted with ASM #5, the Nurse Practitioner. ASM #5 stated that she could not recall the exact timeline of events but she stated that on 11/11/16 she saw that the X-ray was positive for fracture when she arrived to the facility and then she called the family to see if they wanted aggressive treatment. ASM #5 stated that she wrote an order that day for an ortho consult. ASM #5 stated that the ortho consult did not really address the fracture of the right femoral neck because they were treating it like an old fracture. ASM #5 stated that the consult only addressed the bilateral pain to Resident #5's knees. ASM #5 could not recall if she made administration aware of the X-ray results.

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F 225	Continued From page 10 On 12/8/16 at approximately 1130 a.m., Administration was made aware of the above concerns. Facility policy titled, "Abuse Prohibition" documents in part, the following: "...5.1.3 All cases of suspected abuse, neglect, or exploitation require mandatory reporting within one working day to the Department of Health and Human Services..." (1) Celebrex- "Non-steroidal anti-inflammatory drug used to treat mild to moderate pain and help relieve symptoms of arthritis such as swelling, stiffness, and joint pain." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009526/?report=details. (2) Fentanyl Patch- "Fentanyl is a powerful synthetic opioid analgesic that is similar to morphine but is 50 to 100 times more potent. It is a schedule II prescription drug, and it is typically used to treat patients with severe pain or to manage pain after surgery. It is also sometimes used to treat patients with chronic pain who are physically tolerant to other opioids." This information was obtained from The National Institutes of Health https://www.drugabuse.gov/drugs-abuse/fentanyl.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12	F 226	1. Residents #4 & #5 continue to reside at the facility in stable condition. Both residents were assessed and records reviewed.	

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F 226	Continued From page 11 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement abuse policies for two of 26 residents in the survey sample, Resident #4 and Resident #5. 1. The facility staff failed to implement the	F 226	No evidence of abuse, neglect or other injuries of unknown source were identified. 2. Records of current residents were reviewed by the Center Nurse Executive (CNE)/designee to determine any other injuries of unknown source. None were identified during this review. 3. Facility staff in all departments and on all shifts will be re-educated by the Center Executive Director (CED)/designee on the current regulations, requirements and policies specific to resident abuse, neglect, misappropriation and injuries of unknown source. All new employees will receive this information as part of their initial orientation. 4. CNE/designee will conduct audits of resident records, as well as review documentation during standing clinical meetings, to determine compliance with all reporting requirements. Results of the audits and reviews will be reported to the Quality Assurance Committee x3 months for their review.	1/21/17

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facility's abuse policy and report a fracture of unknown origin (fracture tibia on 5/4/16) to the required state agency in a timely manner for Resident #4. In addition the facility failed to complete an investigation for Resident #4's fracture of unknown origin to rule out abuse.

2. The facility staff failed to implement abuse policies and report a fracture of unknown origin (right femoral neck) to the required state agency in a timely manner for Resident #5.

The findings include:

1. Resident #4 was admitted to the facility on 11/15/10 and readmitted on 1/3/11 with diagnoses that included but were limited to: dementia, depression and anemia.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 11/28/16 coded the resident as being severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the nurse's notes dated 5/4/16 at 11:00 documented, "Type: Change in Condition. (Name of resident) is experiencing pain. L (left) ankle/grimacing and yelling when touched. L inner ankle noted to be discolored, L ankle is warm to touch, swollen and painful to touch." There was no documentation regarding how this injury occurred.

Review of the physician's orders dated 5/4/16 documented, "x ray L ankle -- r/o (rule out) fracture." Further review of the physician's orders for 5/4/16 documented, "SEND TO (name of

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hospital) ER (emergency room) TO EVAL (evaluate) + TREAT."

Review of the emergency room note dated 5/4/16 at 9:03 p.m. documented, "(Name of facility) is unsure how the injury happened. Pt (patient) had an x ray done today showing a tib (tibia) fib (fibula) fracture."

Review of the x-ray report dated 5/4/16 at 9:47 p.m. documented, "Impression: Fracture of distal left tibia."

A request was made on 12/8/16 at 9:30 a.m. to ASM (administrative staff member) #2, the nurse executive, for a copy of the facility reported incident (FRI) for Resident #4's 5/4/16 leg fracture of unknown origin. ASM #2 stated, "I brought all the FRIs in." There was no FRI for Resident #4. A request to review the investigation to the injury was made at that time.

An interview was conducted on 12/8/16 at 2:25 p.m. with ASM #2. When asked the process staff follows for an injury of unknown injury, ASM #2 stated, "When we have an incident, the nurse on that shift completes it (the incident report)." When asked what happened next, ASM #2 stated, "The next day we come in and investigate it." When asked to review the investigation for Resident #4's fracture of unknown origin, ASM #2 stated, "Because we had a diagnosis of osteopenia (1) I think it got me off the track and I didn't send it (a FRI) into the state." When asked if an investigation had been completed ASM #2 stated there had not been an investigation.

Review of the facility's policy titled, "Abuse Prohibition" documented, "POLICY (Name of

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company) shall prohibit abuse, neglect, exploitation, involuntary seclusion, and misappropriation of property for resident through the following: ....Investigation of incidents and allegations... 5. Staff shall identify events -- such as suspicions bruising of residents -- occurrences, patterns, and trends that may constitute abuse, and determine the direction of the investigation. 5.1.3 All cases of suspected abuse, neglect, or exploitation require mandatory reporting within one working day to the Department of Health and Human Services...5.1.4 The report must include, but is not limited to, name of resident, date and time incident occurred, circumstances surrounding the incident, where the incident took place, extent of the injury or reaction and necessary treatment, names of any witnesses's, name of person (s) charged with committing the act, recommendations for corrective action, and other information as appropriated. 6. Upon receiving information concerning a report of abuse, the CED (chief executive director) or designee shall: 6.1 Conduct an immediate and thorough investigation which shall focus on: 6.1.1 If abuse or neglect occurred and to what extent...6.2 The investigation shall be thoroughly documented on any state required form, and on the Incident/Accident Investigation. 7. The Resident/Patient Incident Report shall be placed in the resident's medical record. 7.1 Investigation forms, logs and statement shall be stored separately in the CED's office."

No further information was provided prior to exit.

(1) Osteopenia -- Osteopenia is a term to define bone density that is not normal but also not as low as osteoporosis. By definition from the World

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Health Organization osteopenia is defined by bone densitometry as a T score -1 to -2.5. There are many causes for osteopenia including calcium and vitamin D deficiency and inactivity. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/21234807/ 2. The facility staff failed to implement abuse policies and report a fracture of unknown origin (right femoral neck) to the required state agency in a timely manner for Resident #5.

Resident #5 was admitted to the facility on 3/2/2011 and readmitted on 9/9/16 with diagnoses that included but were not limited to type two diabetes, unspecified dementia without behavioral disturbance, muscle weakness, difficulty in walking, hypertension, osteoporosis, breast cancer, heart failure, and hypothyroidism.

Resident #5's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 11/22/16. Resident # 5 was coded as being cognitively impaired in the ability to make daily decisions scoring 07 out of 15 on the BIMS (brief interview for mental status) exam. Resident #5 was coded as requiring extensive assistance from two plus staff members with transfers, bed mobility, toileting, bathing, and locomotion off the unit.

Review of the physician's notes revealed the following note documented by the nurse practitioner on 11/8/16: "Chief complaint: C/O (complaint) pain in B/L (bilateral) legs. History of present illness: 83 y.o. (year old) Caucasian female, a LTC (Long Term Care) resident at (name of facility), hospitalized 9/5 to 9/9 with AMS (altered mental status) due to UTI (Urinary Tract infection) with sepsis, and worsening CHF

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(congestive heart failure). Since her readmission it is apparent that she has had a mental decline as she is more quiet in nature and was not able to answer questions as she has in the past. She is seen today for new reports of pain and management of DM (diabetes mellitus) and hypothyroidism... Diagnoses and Assessment: Res (resident) w/pain (with pain) in hips, pelvis and knees upon movement. Yells at the top of her lungs, will order x-rays. Res (Resident) is not asking for pain med (medication) prn (as needed) so will order celebrex (1) 100 mg (milligrams) po (by mouth) BID (twice a day) w/meals (with meals) and will start low dose fentanyl patch (2) of 12 mcg (micrograms)...Spoke with RP (responsible party) about above concerns, RP verbalized understanding and agrees with POC (Plan of Care)."

Review of Resident #5's physician verbal orders revealed the following order dated 11/8/16: "...3 Celebrex 100 mg 1 cap (capsule) po BID 8 AM and 5 PM with food...4. Fentanyl patch 12 mcg apply patch q72 hours (every 72 hours) for pain...5. X-ray of B/L (bilateral) hips and pelvis for pain...6. X-ray of bilateral knees."

Review of Resident #5's X-ray results revealed that X-ray did not arrive to the facility until 11/9/16 (the following day). The radiology report documented the following: "Hips bilat (bilateral) W (with) pelvis 2 view...Results: Nondisplaced age-indeterminate fracture of the right femoral neck. No fracture of the left hip. Bilateral degenerative changes involving the hips..."

Review of the FRI (Facility Reported Incident) revealed that the fracture of unknown origin was not reported to the OLC (Office of Licensure and

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Certification) until 11/16/16 (6 (six) working days) after the fracture was discovered.

Review of the follow up report dated 11/21/16; revealed that the fracture was determined to be pathological in nature after the investigation was completed. The investigation was initiated on 11/18/16.

Review of the investigation revealed the following note dated 11/18/16 by a nurse who worked on 11/10/16 and 11/11/16, on the 3-11 shift: "I worked 3-11 Nov 10 + 11 (Thur/Fri). Was told in report that XR (X-ray) was negative and that MRI (Magnetic Resonance Imaging) may be considered. No unusual indication / c/o of pain verbalized or reported. Celebrex and Fentanyl patch were ordered 11/8 and were in effect when I worked Nov 10 and 11."

Further review of the investigation revealed a note dated 11/18/16 from the Nurse Practitioner. It documented the following: "She was assessed on 11/8/16 for c/o pain as reported by nursing. X-ray of B/L (Bilateral) hips and pelvis were ordered with physical assessment along with antiinflammatories and pain meds (medications).
11/9/16= X-rays were done and not received until p.m.
11/10/16= I was not in the building.
11/11/16- I followed up X-ray results (+) (positive) for (R) (right) femoral neck fracture. Continued pain med.
11/14/16- Able to contact RP (responsible party) and discussed results of X-ray and POC (Plan of Care) which included continued pain management and ortho (orthopedic) consult. She is NWB (Non Weight Bearing) at this time. Will await recommendations of ortho consultation,

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appt (appointment) has been made."

On 12/7/16 at 2:57 p.m., an interview was conducted with LPN (licensed practical nurse) #5, the nurse who worked 11/10/16 and 11/11/16 3-11 shift. When asked what she could recall about Resident #5's fracture, LPN #5 stated that she was not quite sure how her fracture occurred. When asked about the process staff follows if a resident's X-rays come back positive for a fracture, LPN #5 stated that she would call the NP for notification and to receive new orders, notify the family, and then chart orders that were received. LPN #5 stated that she would talk to staff to see if they know anything about how the resident could have obtained a fracture and notify administration immediately. LPN #5 stated that she was told in report that Resident #5's X-rays were negative on 11/10/16. LPN #5 stated that she did not personally look at the X-ray results because she was told in report that they were negative.

On 12/7/16 at 3:11 p.m., an interview was conducted with LPN #6, the nurse who faxed the orders for the X-rays. LPN #6 stated that she was called in to work part of 7-3 and 3-11 shifts on 11/8/16. LPN #5 stated she saw the orders flagged for the X-ray and pain medication, and she took the orders off and faxed them to pharmacy. LPN #6 also stated that she called for X-ray and notified the family. LPN #6 stated that the X-ray was not ordered STAT (Immediate) and X-ray did not arrive on her shift. LPN #6 stated that if the situation is not an emergency, X-rays will not be ordered STAT. LPN #6 stated that if X-rays are not ordered STAT, they usually arrive to the facility the next day. LPN #6 worked until 11 p.m. that night. When asked the reason for

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the X-ray, LPN #6 stated that she was told the resident was complaining of increased pain and the NP assessed the resident before writing the order. When asked if Resident #5's positive X-ray results should have been reported to administration immediately, LPN #5 stated that Administration should be notified right away so they can start an investigation on how the fracture occurred.

On 12/8/16 at approximately 11:30 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator and ASM (administrative staff member) #2, the DON (Director of Nursing). When asked when an injury of unknown origin should be reported, ASM #2 stated, "Right Away." ASM 1 stated, "Within 24 hours." ASM #2 stated, "This was the delayed FRI (facility reported incident). I think what happened was the NP went to check on her (resident) for an unrelated situation and the resident was in a lot of pain at that time. She ordered X-rays of the bilateral hips and pelvis, and bilateral knees. Whoever the nurse was who looked at the X-rays, saw that one X-ray was negative and thought all X-rays were negative. She left them for NP to view when the NP arrived to facility (11/11/16)." ASM #2 stated that administration was not made aware of the fracture until 11/16/16 and they immediately reported this fracture to the state. ASM #2 stated that they concluded the fracture was pathological given her medical condition.

On 12/8/16 at approximately 1 p.m., an interview was conducted with ASM #5, the Nurse Practitioner. ASM #5 stated that she could not recall the exact timeline of events but she stated that on 11/11/16 she saw that the X-ray was

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positive for fracture when she arrived to the facility and then she called the family to see if they wanted aggressive treatment. ASM #5 stated that she wrote an order that day for an ortho consult. ASM #5 stated that the ortho consult did not really address the fracture of the right femoral neck because they were treating it like an old fracture. ASM #5 stated that the consult only addressed the bilateral pain to Resident #5's knees. ASM #5 could not recall if she made administration aware of the X-ray results.

On 12/8/16 at approximately 11:30 p.m., administration was made aware of the above concerns.

Facility policy titled, "Abuse Prohibition" documents in part, the following: "...5.1.3 All cases of suspected abuse, neglect, or exploitation require mandatory reporting within one working day to the Department of Health and Human Services..."

(1) Celebrex- "Non-steroidal anti-inflammatory drug used to treat mild to moderate pain and help relieve symptoms of arthritis such as swelling, stiffness, and joint pain." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009526/?report=details.

(2) Fentanyl Patch- "Fentanyl is a powerful synthetic opioid analgesic that is similar to morphine but is 50 to 100 times more potent. It is

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F 226	Continued From page 21 a schedule II prescription drug, and it is typically used to treat patients with severe pain or to manage pain after surgery. It is also sometimes used to treat patients with chronic pain who are physically tolerant to other opioids." This information was obtained from The National Institutes of Health https://www.drugabuse.gov/drugs-abuse/fentanyl.	F 226		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to provide medically related social services for one of 26 residents in the survey sample, Resident #3. The facility staff failed to develop and implement interventions to decrease the resident's anxiety related to her roommate's behavior. The findings include: Resident #3 was admitted to the facility on 6/6/16 with diagnoses that included but were not limited to: arthritis, high blood pressure, kidney disease, anxiety and obesity. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment	F 250	1. Consistent with a care-plan meeting on 11/22/16, with Resident Representative (RR), CED & CNE present, Resident #3 was offered a room change on 11/29/16 and refused. Her present status with her roommate was assessed and no further issues identified. 2. Resident or RR requests for room changes will be honored based on availability of an appropriate bed. 3. New residents are assigned rooms based on the information received from the transferring facility. Considerations for placement in semi-private living arrangements for all residents are based on a number of factors including gender, behavior issues, medical status, presence or absence of infections, and transfer status/requirements. Resident requests for a room change are made to Social Services and	

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F 250	Continued From page 22 reference date) of 10/31/16 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating once the tray was set up. A complaint received at the state agency on 11/1/16 alleged, "The complainant states that, "The roommate, (name of roommate), stays up all night keeping my mother up; my mother babysits her and gets stressed out...." Resident #18, the roommate, was admitted to the facility on 3/24/16 and readmitted on 8/16/16 with diagnoses that included but were not limited to: heart failure, stroke and high blood pressure. The most recent MDS assessment was a quarterly assessment, with an ARD of 9/26/16 and coded the resident as being severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. An interview was conducted with Resident #3 on 12/7/16 at 10:15 a.m. When asked how she got along with her roommate, Resident #3 stated, "I didn't sleep at first because I was afraid she was going to fall. She was always trying to get out of bed." When asked what staff had done to decrease her concern for her roommate, Resident #3 stated, "They tell me not to worry about her but if I think she's going to get hurt to call them." Resident #3 stated, "They told me they were going to give me a compatible roommate. Does she look compatible?" When asked if she had been offered a room change, Resident #3	F 250	discussed at daily clinical meetings where feasibility of the request are discussed with the interdisciplinary team. Decisions are then shared with the resident, RP and possible new roommate. 4. Social Services department will log all requests for room changes and the decision made with accompanying rationale. This will be integrated into practice and reported to the Quality Assurance Committee x 3 months.	1/21/17

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stated, "If you complain (about your roommate) you move and I was here first so that's why I don't want to move. I don't think it's fair."

Review of Resident #3's nurse's notes dated 10/31/16 at 10:38 p.m. documented, "Usually she is up in W/C (wheelchair) all eve (evening) watching TV, keeping an eye on her roommate...."

Review of the care plan did not evidence documentation regarding interventions to be used by staff to decrease the resident's concerns related to her roommate.

An interview was conducted on 12/7/16 at 11:15 with OSM (other staff member) #6, the resident's social worker. When asked how roommates were selected, OSM #6 stated, "Compatibility in my mind is that they're able to communicate. That there are no behavioral issues that would impact their roommate." When asked if she thought Resident #3 was compatible with her roommate, OSM #6 stated, "I think there are more compatible roommates for (name of Resident #3)." OSM #6 stated that the interdisciplinary team had discussed the residents and that they had discussed some interventions to decrease Resident #3's concerns. When asked if that would be documented, OSM #6 stated, "I would expect so." When asked if the care plan had been developed, OSM #6 stated "Not currently no." When asked why a care plan would be developed, OSM #6 stated, "Certainly we want the nursing staff to be aware and that there are potential adjust issues with a new roommate. We can make strategies to help them." When asked what strategies had been developed, OSM #6 stated, "Keep her roommate comfortable at night

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and I know that has improved." When asked who was responsible for developing the interventions, OSM #6 stated it was her responsibility.

An interview was conducted on 12/7/16 at 1:10 p.m. with LPN (licensed practical nurse) #5, the nurse caring for Resident #3. When asked how Resident #3 got along with her roommate, LPN #5 stated, "(Name of resident) feels like she should care for her (roommate). We've talked about it and I told her it's not her place to take care of her."

On 12/8/16 at 12:15 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the nurse executive and ASM #3, the regional clinical quality specialist were made aware of the findings.

An interview was conducted on 12/8/16 at 4:30 p.m. with OSM #5, a social worker. When asked how the concerns Resident #3 had about her roommate were communicated to front line staff, OSM #5 stated, "We would develop a plan and put it on the care plan or verbally share it." When asked about the process staff follows if roommates were not compatible, OSM #5 stated, "We try to match residents up. (Name of Resident #3) wasn't' interacting too much with a roommate. When a bed comes open we'll try to accommodate that. She feels it's her responsibility to watch her (the roommate)." When asked who would be moved, OSM #5 stated, "I would offer both of them a room change."

An interview was conducted on 12/8/16 at 4:42 p.m. with CNA (clinical nursing assistant) #4, the aide who cares for Resident #3. When asked how

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Resident #3 got along with her roommate, CNA #4 stated, "(Name of Resident #3) looks out for (name of Resident #18 the roommate). She (Resident #3) feels like she needs to watch out for her. I tell her that's good but you don't have to. She doesn't want anything to happen to her and I don't want her to fall. She (Resident #3) gets nervous when she hears the beep (from the bed alarm)." When asked if she had received any information about interventions that staff should use to decrease Resident #3's concerns, CNA #4 stated, "No."

Review of the facility's job description titled, "Social Services" documented, "POSITION SUMMARY: The Social Services Specialist I works with patients/residents and their family members/significant others within the facility through use of the psychosocial perspective identifying their strengths, social, emotional, and mental health needs along with providing, developing, and/or aiding in the access of services to meet those needs. The Social Services Special I shall provide patient/resident with the highest practical level of physical, mental, and psychosocial well-being and quality of life. Advocacy. 3. Responds to issues identified by patients/residents and families to determine satisfaction with services. Clinical. 3. Participates in the development of a written, interdisciplinary plan of care for each patient/resident that identifies the psychosocial needs/issues of the patient/resident, the goals to be accomplished for those needs/issues, and the appropriate Social Services interventions. 6. Facilitates patient/resident transfer throughout the center to ensure a seamless transition and patient/resident adjustment."

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F 250	Continued From page 26 No further information was provided prior to exit.	F 250		
F 279 SS=D	Complaint deficiency 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 279	1. The care plans for Resident #11 & Resident #13 were revised to include the interventions for the CAAs that were triggered: Urinary Incontinence for Resident #11 and Nutrition for Resident #13. 2. The MDS Coordinator reviewed other residents' records to identify care plans not reflecting triggered CAAs and corresponding interventions, with revisions completed as needed. 3. Nursing staff on all shifts will be in-serviced on the company's Person-Centered Care Plan policy by the CNE/designee. All new nursing employees will receive this information as far as their initial orientation/training. 4. Weekly audits will be conducted by the CNE/designee to determine compliance with resident care plans reflecting all triggered CAAs and needed interventions. Results of the audits will be reported to the Quality Assurance Committee x3 months for their review.	1/21/17

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(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to develop a comprehensive care plan for two of 26 residents in the survey sample, Resident #11 and #13.

1. The facility staff failed to develop a comprehensive care plan from the triggered CAA (Care Area Assessment Summary) in Section V for "Urinary Incontinence" on Resident #11's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of

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11/24/16.

2. For Resident #13, facility staff failed to develop a comprehensive care plan from the triggered CAA area in Section V for "Nutrition" on Resident #13's admission MDS assessment with and ARD date of 11/23/16.

The findings include:

1. Resident #11 was admitted to the facility on 11/7/16 with diagnoses that included but were not limited to cellulitis of the left lower leg, high blood pressure, atrial fibrillation, high cholesterol, dementia with Lewey bodies (1) and heart disease.

Resident #11's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 11/24/16. Resident #11 was coded as being cognitively impaired in the ability to make daily decisions scoring 06 out of 15 on the BIMS (brief interview for mental status) exam. Resident #11 was coded as requiring extensive assistance with walking, locomotion, dressing, toileting, personal hygiene, and bathing; and extensive assistance from staff with transfers.

Resident #11's admission MDS assessment dated 11/24/16 documented the following triggered CAA area under Section V (Care Area Assessment Summary):

"Urinary Incontinence and indwelling catheter." This care area was also checked to be care planned.

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Review of Resident #11's care plan dated 11/21/16, failed to reveal any urinary incontinence interventions.

On 12/7/16 at 2:07 p.m., an interview was conducted with LPN (licensed practical nurse) #2, the MDS nurse. When asked about the process staff follows for developing a care plan from the triggered CAA areas, LPN #2 stated that if an area triggers on the CAAs and it is marked to be care planned, then a care plan should be completed by that department. LPN #2 stated that she completed all nursing related sections such as ADLs (activities of daily living), urinary incontinence, and communication etc. LPN #2 stated that incontinent care interventions are sometimes bunched into the skin care plan. When asked if she could find a urinary incontinent care plan for Resident #11, LPN #2 stated, "It is not here. Either I missed it or somebody else did." LPN #2 stated that she uses the RAI (Resident Assessment Instrument) manual as a reference when completing the MDS.

On 12/7/16 at 6:45 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, (The Director of Nursing) were made aware of the above findings. No further information was presented prior to exit.

Review of the RAI 3.0 manual documents in part, the following: Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions. While reviewing the CAA, consider what MDS items caused the CAA to be triggered. This is also an opportunity to consider any issues and/or conditions that may

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contribute to the triggered condition, but are not necessarily captured in MDS data. Review of CAAs helps staff to decide if care plan intervention is necessary, and what types of intervention may be appropriate. Using the results of the assessment can help the interdisciplinary team (IDT) and the resident and/or resident's representative to identify areas of concern that:

· Warrant intervention
· Affect the resident's capacity to help identify and implement interventions to improve, stabilize, or maintain current level of function to the extent possible, based upon the resident ' s condition and choices and preferences for interventions;
· Can help to minimize the onset or progression of impairments and disabilities; and
· Can help to address the need and desire for other specialized services (e.g. palliative care, including symptom relief and pain management).

2. For Resident #13, facility staff failed to develop a comprehensive care plan from the triggered CAA area "Nutrition."

Resident #13 was admitted to the facility on 11/16/16 with diagnoses that included but were not limited to acute spondylosis, high blood pressure, Alzheimer's disease, type two diabetes mellitus, a burn to the right leg that occurred at home and occlusion of unspecified vertebral artery.

Resident #13's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 11/23/16. Resident #13 was coded as being cognitively intact in the ability to make daily decisions scoring

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14 out of 15 on the BIMS (brief interview for mental status) exam. Resident #13 was coded as requiring extensive assistance from staff with transfers, locomotion, dressing, toileting, personal hygiene, and bathing.

Resident #13's admission MDS assessment dated 11/23/16 documented the following triggered CAA area under Section V (Care Area Assessment Summary):

"Nutrition." This care area was also checked to be care planned.

Review of Resident #13's care plan dated 11/29/16, failed to reveal any nutrition interventions.

On 12/7/16 at 2:40 p.m., an interview was conducted with OSM (other staff member) #4, the Dietary Manager. When asked about the process staff follows for developing a care plan from the triggered CAAs, OSM #4 stated, "You would do a care plan with anyone deemed at risk for nutritional issues and I would also visit more often; monthly instead of quarterly for an assessment." OSM #4 was asked if she did the CAA worksheet for the area "Nutritional Status" on Resident #13's admission MDS dated 11/23/16. OSM #4 stated, "I don't believe I did that particular one but if I said I was going to do a care plan there would be a care plan. I am not sure who completes these sections other than me." OSM #4 stated that she could not find a nutritional care plan for Resident #13. On 12/7/16, at 2:45 p.m., OSM #4 stated, "Because the skin section triggered for a burn when she was admitted here, the MDS system automatically triggered for nutrition, but she did

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not need a nutritional care plan at that time. The MDS should have said NO to care planning decision."

On 12/7/16 at 6:45 p.m., administration (ASM) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above findings.

Facility policy titled, "Person-Centered Care Plan" documents in part, the following: "The interdisciplinary team, in conjunction with the patient and/or resident representative, as appropriate, will establish the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. Documentation will show evidence of: Patient's goals and preferences; Patient's status in triggered Care Area Assessments (CAAs); Development of care planning interventions for all CAAs triggered by the MDS; and Rationale for not care planning for a specific triggered CAA."

No further information was presented prior to exit.

(1) Lewey Bodies Dementia-"Lewy body dementia is one of the most common forms of progressive dementia. People affected by this condition may experience a variety of symptoms such as changes in alertness and attention; hallucinations; problems with movement and posture; muscle stiffness; confusion; and/or memory loss. Although the exact cause of Lewy body dementia is poorly understood, symptoms are thought to result when clumps of a protein called alpha-synuclein ("Lewy bodies") accumulate in the brain." This information was

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F 279	Continued From page 33 obtained from The National Institutes of Health https://rarediseases.info.nih.gov/diseases/3243/lewy-body-dementia.	F 279		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 280	1. The comprehensive care plans for all of the affected residents were updated during the survey. 2. The MDS Coordinator reviewed other records to identify resident care plans requiring updates, with updates completed as needed. 3. Nursing staff on all shifts will be in-serviced on the company's Person-Centered Care Plan policy by the CNE/designee. All new nursing employees will receive this information as far as their initial orientiation. Morning clinical meetings will include updating all care plans that are reflected on the 24-hour or risk-management reports. 4. Weekly audits will be conducted by the CNE/designee to determine compliance with resident care plans. Results of the audits will be reported to the Quality Assurance Committee x3 months for their review.	1/21/17

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

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

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

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

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

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(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for five of 26 residents in the survey sample, Residents #10, #7, #3, #4 and #5.

1. The facility staff failed to revise Resident #10's comprehensive care plan to include a right ankle clam shell brace ordered on 8/4/16.

2. The facility staff failed to revise Resident #7's comprehensive care plan to include the discontinuation of a Foley urinary catheter (discontinued on 10/4/16).

3. The facility staff failed to review and revise Resident #3's comprehensive care plan to address Resident #3's anxiety related to her roommate and to include include interventions to be used to decrease the resident's anxiety related to her roommate's behavior.

4. The facility staff failed to develop a comprehensive care plan for the care of Resident #4's left leg splint.

5. The facility staff failed to review or revise the comprehensive care plan after a stage two pressure ulcer was found on Resident #5's left heel.

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The findings include:

1. The facility staff failed to revise Resident #10's comprehensive care plan to include a right ankle clam shell brace ordered on 8/4/16.

Resident #10 was admitted to the facility on 6/25/16. Resident #10's diagnoses included but were not limited to: displaced ankle fracture of the right lower extremity, chronic kidney disease and heart failure.

Resident #10's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 9/19/16, coded the resident's cognition as being severely impaired. Section G coded the resident as requiring extensive assistance of one staff with bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene and bathing.

An orthopedist consult note dated 8/4/16 documented, "S/P (Status post) ORIF (open reduction internal fixation [surgical procedure]) Right ankle fx (fracture). Skin intact, incisions well-healed...Recommendations: Weight bearing as tolerated with walker and assistance/observation at all times. Fall Risk. 2. Wear ankle clam shell/ (illegible word) brace at all times. Wear thick sock underneath at all times to protect skin..."

A physician's order dated 8/4/16 documented, "Weight bearing as tolerated with walker & (and) assistance /observation at all times. Wear ankle clam shell brace at all times, wear thick sock underneath-protect skin. F/U (follow up) in 4 wks (weeks)." The brace was discontinued on 8/24/16.

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Resident #10's comprehensive care plan initiated on 7/5/16 and active during the time period of 8/4/16 through 8/16/16 documented, "Resident is at risk for skin breakdown as evidenced by limited mobility, incontinence...Weekly skin assessment by license nurse..." The care plan failed to document any information regarding the resident's clam shell brace.

On 12/8/16 at 11:16 a.m., an interview was conducted with RN (registered nurse) #1 (unit manager). RN #1 confirmed residents' care plans should be updated when a resident receives a new order for a brace. RN #1 was asked how staff would know how to care for a brace if it was not documented on the care plan. RN #1 stated, "That's why it should be care planned." At this time, RN #1 was asked to look at Resident #10's care plan and verify that it was not revised to include the ankle clam shell brace ordered on 8/4/16. RN #1 stated she would get back to this surveyor.

On 12/8/16 at 12:00 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the nurse executive) were made aware of the above findings.

On 12/8/16 at 4:10 p.m., LPN (licensed practical nurse) #2 (MDS coordinator) confirmed Resident #10's care plan had not been revised to include the brace ordered on 8/4/16.

The facility policy titled, "Person-Centered Care Plan" documented, "Care plans will be: 5.2 Reviewed and revised a minimum of quarterly and as needed to reflect the response to care and changing needs and goals..."

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No further information was presented prior to exit.

2. The facility staff failed to revise Resident #7's comprehensive care plan to include the discontinuation of a Foley urinary catheter (1) (discontinued on 10/4/16).

Resident #7 was admitted to the facility on 1/28/11. Resident #7's diagnoses included but were not limited to: heart failure, shortness of breath and high blood pressure.

Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/7/16 coded the resident's cognition as being severely impaired. Section H coded Resident #7 as always incontinent of bladder and as not having an indwelling catheter.

Review of Resident #7's clinical record revealed a physician's order dated 10/4/16 to discontinue the resident's Foley catheter. Review of Resident #7's comprehensive care plan created on 4/4/16 documented, "Resident requires indwelling foley catheter related to wound(s)...Interventions: Catheter care as indicated. Keep catheter off floor. Leg bag when appropriate. Provide privacy bag..."

On 12/6/16 at 3:08 p.m., Resident #7 was observed sitting up in bed. No Foley catheter was observed.

On 12/7/16 at 7:46 a.m., Resident #7 was observed lying in bed. No Foley catheter was observed.

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On 12/7/16 at 2:25 p.m., an interview was conducted with RN (registered nurse) #1 (unit manager). RN #1 stated she and the MDS coordinators update care plans but any nurse could update a care plan. RN #1 confirmed a care plan should be updated when a Foley catheter is discontinued. RN #1 stated the nurse who received the discontinuation order should have been able to update the care plan and the unit manager has to follow up to make sure the update is done.

On 12/7/16 at 6:45 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the nurse executive) were made aware of the above findings.

On 12/8/16 at 7:47 a.m., LPN (licensed practical nurse) #2 (the MDS coordinator) stated she had removed the Foley catheter documentation from Resident #7's care plan.

No further information was presented prior to exit.
(1) A Foley urinary catheter is a tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm

3. The facility staff failed to review and revise Resident #3's comprehensive care plan to

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address Resident #3's anxiety related to her roommate and to include interventions to be used to decrease the resident's anxiety related to her roommate's behavior.

Resident #3 was admitted to the facility on 6/6/16 with diagnoses that included but were not limited to: arthritis, high blood pressure, kidney disease, anxiety and obesity.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 10/31/16 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating once the tray was set up.

A complaint received to the state agency on 11/1/16 alleged, "The complainant states that, "The roommate, (name of roommate), stays up all night keeping my mother up; my mother babysits her and gets stressed out...."

Resident #18, the roommate, was admitted to the facility on 3/24/16 and readmitted on 8/16/16 with diagnoses that included but were not limited to: heart failure, stroke and high blood pressure.

On the most recent MDS, a quarter assessment, with an ARD of 9/26/16 coded the resident as being severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

An interview was conducted with Resident #3 on 12/7/16 at 10:15 a.m. When asked how she got

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along with her roommate, Resident #3 stated, "I didn't sleep at first because I was afraid she was going to fall. She was always trying to get out of bed." When asked what staff had done to decrease her concern for her roommate, Resident #3 stated, "They tell me not to worry about her but if I think she's going to get hurt to call them." Resident #4 stated, "They told me they were going to give me a compatible roommate. Does she look compatible?"

Review of Resident #3's nurse's notes dated 10/31/16 at 10:38 p.m. documented, "Usually she is up in W/C (wheelchair) all eve (evening) watching TV, keeping an eye on her roommate...."

Review of the care plan did not evidence documentation regarding interventions to be used by staff to decrease the resident's concerns related to her roommate.

An interview was conducted on 12/7/16 at 11:15 with OSM (other staff member) #6, the social worker. When asked how roommates were selected, OSM #6 stated, "Compatibility in my mind is that they're able to communicate. That there are no behavioral issues that would impact their roommate." When asked if she thought Resident #3 was compatible with her roommate, OSM #6 stated, "I think there are more compatible roommates for (name of Resident #3)." OSM #6 stated that the interdisciplinary team had discussed the residents (Resident #3 and Resident #18 the roommate) and that they had discussed some interventions to decrease Resident #3's concerns. When asked if that would be documented, OSM #6 stated, "I would expect so." When asked if the care plan had

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been developed, OSM #6 stated "Not currently no." When asked why a care plan would be developed, OSM #6 stated, "Certainly we want the nursing staff to be aware and that there are potential adjustment issues with a new roommate. We can make strategies to help them." When asked what strategies had been developed, OSM #6 stated, "Keep her roommate comfortable at night and I know that has improved."

An interview was conducted on 12/7/16 at 1:10 p.m. with LPN (licensed practical nurse) #5, the nurse caring for Resident #3. When asked how Resident #3 got along with her roommate, LPN #5 stated, "(Name of resident) feels like she should care for her (roommate). We're talked about it and I told her it's not her place to take care of her."

On 12/8/16 at 12:15 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the nurse executive and ASM #3, the regional clinical quality specialist were made aware of the findings.

An interview was conducted on 12/8/16 at 4:30 p.m. with OSM #5, a social worker. When asked how the concerns Resident #e had about her roommate were communicated to front line staff, OSM #5 stated, "We would develop a plan and put it on the care plan or verbally share it."

An interview was conducted on 12/8/16 at 4:42 p.m. with CNA (clinical nursing assistant) #4, the aide who cares for Resident #3. When asked how Resident #3 got along with her roommate, CNA #4 stated, "(Name of Resident #3) looks out for (name of Resident #18, roommate). She feels

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like she needs to watch out for her. I tell her that's good but you don't have to. She doesn't want anything to happen to her and I don't want her to fall. She (Resident #3) gets nervous when she hears the beep (from the bed alarm)." When asked if she had received any information about interventions that staff should use to decrease Resident #3's concerns, CNA #4 stated, "No."

No further information was provided prior to exit.

4. The facility staff failed to develop a comprehensive care plan for the care of Resident #4's left leg splint.

Resident #4 was admitted to the facility on 11/15/10 and readmitted on 1/3/11 with diagnoses that included but were limited to: dementia, depression and anemia.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 11/28/16 coded the resident as being severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the nurse's notes dated 5/4/16 at 11:00 documented, "Type: Change in Condition. (Name of resident) is experiencing pain. L (left) ankle/grimacing and yelling when touched. L inner ankle noted to be discolored, L ankle is warm to touch, swollen and painful to touch."

Review of the emergency room discharge instructions dated 5/4/16 documented, "Splint Application: Posterior short leg fiberglass splint applies to left lower leg. Wear splint until

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released. Follow-up with: (Name of doctor). Follow up tomorrow."

Review of the physician's orders did not evidence documentation regarding the splint.

Review of the nurse's notes dated 5/5/16 at 1:11 p.m. documented, "Area remains painful to touch LLE (left lower extremity) remains in soft cast." [Note: a fiberglass splint is not soft but rigid.]

An interview was conducted on 12/7/16 at 2:45 p.m. with LPN (licensed practical nurse) #1, the wound nurse. When asked who updated the care plan when a resident had a splint, LPN #1 stated that she did not know but it was not her.

An interview was conducted on 12/8/16 at 11:07 a.m. with RN (registered nurse) #1, the unit manager. RN #1 was asked when care plans were updated. RN #1 stated, "Any change in conditions, falls, skin tears, all new changes, we have to update the care plan." When asked why it was important to update the care plan, RN #1 stated, "To make sure we are current in our plan of care." When asked who would update the care plan when a resident had a splint, RN #1 stated, "The wound nurse, the nurse. Everyone should update the care plan." When asked to review Resident #4's care plan for documentation of the splint that was applied on 5/4/16, RN #1 could not locate documentation regarding the splint.

On 12/8/16 at 12:15 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the nurse executive and ASM #3, the regional clinical quality specialist were made aware of the findings.

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An interview was conducted on 12/9/16 at 1:45 p.m. with LPN #2, the MDS coordinator. When asked who updated the resident's care plan, LPN #2 stated, "The ADON (assistant director of nursing) or the nurses on the floor." When asked if a care plan would be updated if a resident had a splint applied, LPN #2 stated, "Yes."

No further information was provided prior to exit.

5. The facility staff failed to review or revise the comprehensive care plan after a stage two pressure ulcer was found on Resident #5's left heel.

Resident #5 was admitted to the facility on 3/2/2011 and readmitted on 9/9/16 with diagnoses that included but were not limited to type two diabetes, unspecified dementia without behavioral disturbance, muscle weakness, difficulty in walking, hypertension, osteoporosis, breast cancer, heart failure, and hypothyroidism.

Resident #5's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 11/22/16. Resident # 5 was coded as being cognitively impaired in the ability to make daily decisions scoring 07 out of 15 on the BIMS (brief interview for mental status) exam. Resident #5 was coded as requiring extensive assistance from two plus staff members with transfers, bed mobility, toileting, bathing, and locomotion off the unit.

Review of Resident #5's skin integrity report dated 11/22/16 revealed the following: "Initial

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Wound Date: 11/22/16, Initial Stage: two...anatomical location: L (left) heel."

Review of Resident #5's care plan dated 11/11/16 revealed that pressure prevention interventions were put into place prior to the development of the stage two heel ulcer. Review of Resident #5's care plan failed to show that the care plan was reviewed or revised after the discovery of a stage two pressure ulcer on Resident #5's left heel.

Review of Resident #5's physician telephone orders revealed that different treatments were put into place to treat Resident #5's left heel ulcer.

On 12/7/16 at 2:57 p.m., an interview was conducted with LPN (licensed practical nurse) #5, the nurse who found the open area. When asked who was responsible for updating the care plan for each resident, LPN #5 stated that she was not sure. LPN #5 stated, "I think it's MDS but I am not quite sure." When asked when a care plan would be updated, LPN #5 stated for any change in condition such as a resident refusing showers, eating habits. When asked if skin alterations or pressure areas would be documented on the care plan, LPN #5 stated, "I don't know about pressure." When asked if she updated the care plan after she discovered the open area to Resident #5's heel, LPN #5 stated, "I did not."

On 12/7/16 at approximately 2:10 p.m., an interview was conducted with RN (Registered Nurse) #3. RN #3 stated that nurses on the unit were responsible for updating the care plan for issues such as falls, infections, catheters etc. RN #3 stated the nurse who recognizes the change in condition is responsible for updating the care plan. When asked if skin conditions should be

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F 280	Continued From page 47 placed on the care plan, RN #3 stated, "Yes it should be on Care Plan." On 12/7/16 at 3:11 p.m., an interview was conducted with LPN #6. When asked what the purpose of the care plan was, LPN #6 stated, "To let you know about the patient's welfare, condition or a change in condition." When asked when the care plan is updated, LPN #6 stated that the care plan is updated with any issues with pain, falls, wounds or any major change. When asked who is responsible for updating the care plan, LPN #6 stated that unit managers, supervisors, and sometimes the floor nurses update the care plan. On 12/7/16 at approximately 6:45 p.m., ASM (Administrative Staff Member) #1, the Administrator and ASM #2, (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. Facility policy titled, "Person Centered Care Plan" did not address updating the care plan.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that	F 281	1. The code status of Resident #1 Code status was corrected, consistent with the corresponding physician order and advance directive on the chart. 2. Current residents' records were reviewed to determine accuracy regarding current and desired code status. No other issues were identified. 3. A chart review will be conducted by the CNE/designee during	

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F 281	Continued From page 48 the facility staff failed to follow professional standards of practice for one of 26 residents in the survey sample, Resident #1. The facility staff failed to transcribe a Durable Do Not Resuscitate Order to Resident #1's physician's order form. The findings include: Resident #1 was admitted to the facility on 3/4/15. Resident #1's diagnoses included but were not limited to: stroke, obesity and chronic kidney disease. Resident #1's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/17/16, coded the resident as being cognitively intact. Review of Resident #1's clinical record revealed a "Durable Do Not Resuscitate Order" signed by Resident #1, the resident's physician and dated 1/28/16. The form documented, "I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify (must check 1 or 2): (a check mark beside) 1. The patent is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)...I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation	F 281	month-end change-over, and newly-admitted residents will have their advance directives reviewed and appropriately coded. Nursing staff will be re-educated by the CNE/designee on the accurate transcription of physician orders. All new orders will be reviewed at the morning clinical meetings. 4. A facility-wide review of all orders for accuracy will be conducted by the CNE/designee. New orders/changes that involve advance directives will be reported to the monthly QA committee x3 months.	1/21/17

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and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain."

Further review of Resident #1's clinical record revealed a physician's order form signed by the physician on 12/6/16 that documented, "CODE STATUS: YES- ATTEMPT CPR-FULL CODE"

Resident #1's comprehensive care plan revised on 10/25/16 failed to document information regarding the resident's code status.

On 12/7/16 at 2:25 p.m., an interview was conducted with RN (registered nurse) #1 (unit manager). RN #1 was asked if residents' DNR (Do Not Resuscitate) forms were ever compared to their physician order forms. RN #1 stated the DNR forms are compared with the physician order forms with a change in condition, when residents are readmitted from the hospital and during care plan meetings. RN #1 was asked what should be documented on the physician's order form when a resident had a DNR. RN #1 stated the physician order form should document "DNR." RN #1 was asked what documentation nurses would look at to determine if CPR (cardiopulmonary resuscitation) should be initiated if a resident coded (the resident's heart stopped beating). RN #1 stated nurses would look at the order and the DNR form. RN #1 was asked what would happen if Resident #1 coded because he had a DNR form and an order documented as "full code" on his physician's

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F 281	Continued From page 50 order form. RN #1 stated, "I'm going to double check." On 12/7/16 at 6:45 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the nurse executive) were made aware of the above findings. At this time, this surveyor requested the facility policy and facility standard of practice regarding the above matter. The facility standard of practice was not provided prior to the end of the survey. The facility policy titled, "Transcription of Orders" documented, "POLICY: Orders from an authorized licensed independent practitioner are transcribed by a licensed nurse. Written orders may be transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must verify accuracy and sign off on orders transcribed by a HUC. PURPOSE: To communicate all practitioner orders to caregivers regarding patient's care and treatment..." No further information was presented prior to exit.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management.	F 309	1. Resident #26 is no longer in the facility. 2. CNE/designee reviewed resident records to determine timely management of pain. No other residents were affected by this deficient practice. 3. The Admissions Department will identify whether pain management is required for any re-admissions or new admissions, that these individuals receive the pain	

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F 309	Continued From page 51 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review it was determined that facility staff failed to maintain the highest level of wellbeing for one of 26 residents in the survey sample, Resident #26. The facility staff failed to assess pain levels before and after the administration of pain medication and failed to administer pain medications timely to treat Resident #26's pain. The findings include: Resident #26 was admitted to the facility on 3/11/16 with diagnoses that included but were not limited to aftercare following joint replacement surgery, presence of right artificial hip joint, osteoarthritis, high blood pressure, high cholesterol, anemia, major depressive disorder, and anxiety disorder. Resident #26 most recent MDS (minimum data set) assessment was a five day scheduled assessment with an assessment reference date	F 309	medication prior to transfer to the facility, and that the individual arrives at the facility with a corresponding physician order so that the medication can be requested immediately by the admitting nurse from the pharmacy. All new admissions will be assessed for pain behaviors using pain assessment and their pain managed appropriately. The pharmacy will be immediately notified by the admitting nurse whenever the prescribed medication is not available in the stat box. Nursing staff on all shifts will be re-educated by the CNE/designee on the facility policy Pain Management. 4. CNE/designee will regularly review the stat box with the pharmacy representative, and review all admissions and provide timely procurement of medications so that the resident has an easy transition Monthly audits will be conducted by the CNE/designee specific to timely pain management, with pro-active measures to minimize pain will be addressed daily.	

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F 309	Continued From page 52 of 3/16/16. Resident #26 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (brief interview for mental status exam). Resident #26 was coded as requiring supervision with transferring, walking, dressing, toileting, personal hygiene, and bathing; and independent with meals and locomotion. Review of Resident #26's most recent POS (physician order sheer) revealed the following order: "Hydrocodone-Acetaminophen (Norco) 7.5 mg/325 mg (milligrams) 1-2 tabs (tablets) PO (by mouth) every four hours prn (as needed) pain." This order was clarified on 3/14/16 to the following: "Give 1 Norco 7.5/325 mg po q 4 hours prn mild to moderate pain...Give 2 Norco 7.5/325 mg po q 4 hours prn mod (moderate) to severe pain." Review of Resident #26's care plan dated 3/12/16 documented the following: "Focus: Resident exhibits or is at risk for alterations in functional mobility related to hip replacement...Goal: Resident will be supported to return to prior level of independence and mobility with necessary adaptations in 90 days...Interventions: Medicate as ordered and observe for effectiveness and monitor for side effects , report to physician as indicated...Monitor for pain and stiffness, medicate as ordered and report to physician as indicated. Review of the nursing notes revealed the following note dated 3/16/16 at 1:06 a.m.: "Pt (patient) became very upset about pain medication. Pharmacy contacted, and pain medication was re-ordered and reported to be	F 309	Results of these audits will be reviewed at the monthly QA Committee meetings x3 months.	1/21/17

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delivered stat. This nurse went to patient and offered non-pharmacological pain interventions until Norco arrived from pharmacy. Pt (patient) requested an ice pack and to lie in bed. Ice pack provided to patient and pt assisted into reclining position in bed. This nurse offered to contact to contact the physician and request either Tylenol or ibuprophen on her behalf. Pt denied offer stating, "If I take that now, I won't be able to take the Norco when it gets here. I will just wait." Pt placed her c-pap mask on and stated "I'll just try to relax. Please bring me my medicine when it gets here."

Review of the narcotic log revealed that Resident #26's last dose of Norco was on 3/15/16 at 5 p.m. A pain score was not documented. A note documenting pain medication effectiveness was not found.

Further review of the narcotic log for Norco 7.5/325 mg revealed that Resident #26 did not receive her Norco until 3:40 a.m. on 3/16/16. A pain score was not documented when she received her medication. A note could not be found documenting pain medication effectiveness.

Review of the facility's emergency stat box revealed that Norco 7.5 /325 mg was not available in the stat box.

On 12/8/16 at 9:04 a.m., an interview was conducted with LPN (licensed practical nurse) #9, a nurse who worked with Resident #26. When asked about the process staff follows when refilling resident pain medications, LPN #9 stated that nursing staff should refill pain medications before it runs out. LPN #9 stated that she waits

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until 10 or 12 tablets are left in the package before she will refill the medication. LPN #9 stated that it is never ok to run out of pain medication especially if they are narcotics. LPN #9 stated that issues can arise with narcotics further delaying the refill process such as pharmacy needing a hard script. LPN #9 stated that if a resident does run out of pain medication, the physician must be notified to get an alternative medication.

On 12/8/16 at 9:37 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated that Resident #26's Norco was not available because the facility did not have a hard script. ASM #2 stated that the resident had a history of drug seeking behavior.

On 12/8/16 at 10:06 a.m., an interview was conducted with RN (registered nurse) #4. RN #4 stated that she refills medications three days before it runs out. RN #4 stated that if a resident runs out of pain medication she would call pharmacy and have them STAT (Immediate) out the medication. She stated that she will also call pharmacy to obtain a code to get the medication out of the STAT box. When asked the process staff follows if the medication is not in the STAT box, RN #4 stated, "I would call the MD (medical doctor) for a different prescription."

On 12/8/16 at 10:17 p.m., an interview was conducted with LPN (licensed practical nurse) #8, a nurse who was familiar with Resident #26. LPN #8 stated that he would refill a medication when about 6 pills are left in the package. He stated that sometimes pharmacy will require a hard script for pain narcotics so it is important to refill

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these medications right away.

On 12/8/16 at 11:11 a.m., an interview was conducted with RN #6, the nurse who worked the shift when Resident #26's pain medication ran out. RN #6 stated that she will usually re-order pain medication three days prior to the medication running out. RN #6 stated that night (3/16/16) pharmacy was stating that they did not have the original prescription for Resident #26's Norco and could not refill the medication. Resident #26 tried explaining to pharmacy that this medication was refilled before, so they must have the original prescription. RN #6 stated that she offered Resident #26 alternative pain medications until she could work out the issue with pharmacy, but the resident declined. Because the resident declined, RN #6 did not call the doctor for alternative pain medication. RN #6 could not explain why the facility staff waited until the medication was out before it was refilled. RN #6 could not recall if she had documented a pain score when the resident finally did receive her Norco or if she documented pain level at least 30 minutes after the Norco was received.

On 12/8/16 at approximately 12:02 p.m., ASM #1 (administrator) and ASM #2 (director of nursing) were made aware of the above findings.

Facility policy titled, "Pain Management" documents in part, the following: "...5. If PRN medications are given document on the back of the MAR (Medication Administration Record) or on the PRN Pain Management flow sheet. 6. Center staff will report any observation or communication of pain to the nurse responsible for that patient...8. Patients receiving

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F 309	Continued From page 56 interventions for pain will be monitored for the effectiveness and side effects in providing pain relief. Document: 8.1 Effectiveness of pain medications. 8.2 Ineffectiveness of routine or PRN medications including interventions, follow-up, and physician/APN/PA notification; 8.3 Side effects, if present and notification of physician/APN/PA; 8.4 Non-pharmacological interventions and effectiveness." No further information was presented prior to exit.	F 309		
F 314 SS=D	COMPLAINT DEFICIENY 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 314	1. During the survey, Residents #4 & #10 were addressed, physician orders obtained, and Treatment Administration Records (TARs) initiated to establish compliance. 2. A facility-wide skin sweep was conducted on 12/12/16 by three Nurse/CNA teams, to identify and address other residents who might be affected by the deficient practice, with treatment regimens initiated or revised as necessary and appropriate per the attending physician or physician extender. 3. Nursing staff on all shifts will be re-educated by the CNE/designee on the facility cast/splint policy and pressure-sore prevention, and the facility Stop-And-Watch	

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F 314	Continued From page 57 Based on observation, staff interview, facility policy review and clinical record review, it was determined that the facility staff failed to provide care and services for pressure ulcer prevention for two of 26 residents in the survey sample, Resident #4 and Resident #10. 1. On 5/4/16 emergency room discharge instructions documented that the resident had a left leg splint. The facility staff failed to seek clarification from the physician regarding the removal of the splint and skin assessments underneath the splint. A skin assessment dated 5/13/16 documented a deep tissue injury (DTI) [1] on Resident #4's left heel. 2. On 8/4/16 Resident #10's orthopedist wrote an order for an ankle clam shell brace. The facility staff failed to seek clarification regarding removal of the brace and skin assessments for the area underneath the brace. A skin assessment dated 8/16/16 documented a deep tissue injury (1) on the resident's right inner ankle and a stage two pressure ulcer (1) on the resident's right outer ankle. The findings include: 1. Resident #4 was admitted to the facility on 11/15/10 and readmitted on 1/3/11 with diagnoses that included but were limited to: dementia, depression and anemia. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 11/28/16 coded the resident as being severely impaired cognitively. The resident	F 314	reporting tool reviewed with staff in all departments by the CED/designee to optimize early detection of any skin issues. Bi-Weekly skin assessments on resident shower days will be enforced by the Nurse Unit Managers. The Nurse Unit Managers will complete weekly wound rounds on their respective residents to ensure treatment protocols are initiated and followed. A dietitian will be included on these rounds as indicated, as well as notified of any new IHA pressure sores. 4. All skin assessments will be reviewed by the CNE/designee and reviewed at the monthly QA Committee meetings x6 months. Monthly audits of IHA notification to the dietician will be completed by the CNE/designee, with the results of these audits reviewed at the monthly QA Committee meetings x6 months.	1/21/17

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was coded as requiring assistance from staff for all activities of daily living.

Review of the nurse's notes dated 5/4/16 at 11:00 documented, "Type: Change in Condition. (Name of resident) is experiencing pain. L (left) ankle/grimacing and yelling when touched. L inner ankle noted to be discolored, L ankle is warm to touch, swollen and painful to touch." There was no evidence of documentation related to if the staff were aware of how the injury occurred.

Review of the nurse practitioner's note dated 5/4/16 at 1:29 p.m. documented, "Will order x-ray of L (left) ankle d/t (due to) possible pathological fx (fracture). Staff reports no falls or recent trauma.

Review of the physician's orders dated and signed on 5/4/16 at 4:15 p.m. documented, "SEND TO (name of hospital) ER (emergency room) to EVAL (evaluate) + TREAT."

Review of the emergency room discharge instructions dated 5/4/16 documented, "Closed nondisplaced fracture of the distal aspect of the left tibia. Splint Application: Posterior short leg fiberglass splint applied to left lower leg. Wear splint until released. Follow-up with: (Name of doctor). Follow up tomorrow." Review of the x-ray results on 5/6/16 at 9:47 p.m. documented, "Fracture of distal left tibia."

Review of the physician's orders dated and signed on 5/5/16 at 4:30 p.m. documented, "POSTERIOR BRACE/CAST TO LLE (left lower extremity) KEEP BRACE/CAST DRY AT ALL TIMES. CMS (circulation, movement and

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sensation) CHECKS TO LLE Q (every) SHIFT. FU (follow up) WITH (name of orthopedic doctor)."

Review of the nurse practitioner's (NP) note dated 5/5/16 documented that the resident's responsible party (RP) did not want the resident to have follow up with the orthopedic doctor as she did not want the resident to have any further procedures done to the fracture.

Review of the physician's orders did not evidence further orders related to the care of the splint following the RP's refusal for the resident to be seen by the orthopedic doctor that day (the day the splint was to be removed).

Review of the May 2016 treatment administration record documented, "Posterior brace/cast to LLE CMS checks to LLE Qshift. Keep brace/cast dry at all times." There were nurse's initials documented on each shift on each day from 5/5/16 to 5/31/16 indicating the CMS (circulation, movement and sensation) checks were done.

Review of the resident's care plan did not evidence documentation regarding the left leg splint.

Review of the nurse's notes dated 5/5/16 to 5/9/16 documented:
5/5/16 at 1:11 p.m. remains painful to touch LLE (left lower extremity) remains in soft cast." [Note: a fiberglass splint is not soft but rigid.]
5/5/16 6:29 p.m. Posterior brace/cast to LLE; keep brace/cast dry at all times; CMS (circulation, movement and sensation) checks to LLE Q (every) shift; f/u (follow up) with (name of orthopedic doctor)."

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5/6/16 1:11 p.m. "Soft cast remains in place to L (left) ankle s/p (status post) fx (fracture). Skin is warm and dry."
5/7/16 at 1:42 a.m. "Soft cast in place to left ankle. CMS checks at patient baseline."
5/7/16 at 8:00 p.m. "Soft cast intact left leg, toes are warm and pink with CRF (capillary refill) < 3 seconds....Monitor circulation status of left foot & for any acute changes or increased S/S (signs and symptoms) of pain in left leg.
5/8/16 at 11:00 a.m. "Soft cast to LLE still intact, CMS checks completed per orders."
5/9/16 at 11:15 a.m. "Soft cast to LLE still intact, CMS checks completed per orders." There were no further nurse's notes related to the splint until 5/13/16. There was no evidence documented that the splint had been removed or that the skin had been assessed during that time.

Review of the nurse's notes dated 5/13/16 at 3:04 p.m. "(Name of resident) has a new onset/change in skin integrity as evidenced by ulcer-pressure. Location: DTI (deep tissue injury) noted to left heel measuring 2x3cm (centimeters)."

Review of the nurse's notes dated 5/13/16 at 4:02 p.m. documented, "N.O. (new order) remove cast to LLE, cleanse heel (with) NS (normal saline)/WC (wound cleanser) apply granulex, wrap (with) kling (gauze dressing) then reapply stocking, white cloth wrap, fiber glass splint and ACE bandage QD (every day). ortho (orthopedic) consult d/t (due to) fx of L tibia -- please assess use of different device secondary to pressure on L (left) heel from splint."

Review of the nurse practitioner's noted dated 6/6/16 at 12:37 p.m. documented, "Will DC (discontinue) splint d/t worsening of wound will

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cont (continue) granulex. Discussed this with the Medical Director who agrees with this PoC (plan of care). Soft heel cushion to be ordered."

Review of the orthopedic doctor's note on 6/16/16 did not evidence documentation regarding using a different device.

Review of the nurse's note dated 5/13/16 at 3:05 p.m. documented, "A Braden Scale was completed today resulting (sic) in a score of 12." A Braden score of 10-12 is considered high risk for skin breakdown.

Review of the facility's skin integrity weekly reports from 5/13/16 to 11/29/16 documented that the wound had gone from an intact deep purple wound to 100 percent eschar (2) and could not be staged until 11/4/16 when the wound was documented to have 75 percent granulation tissue (3) and slough (4). On 11/4/16 the wound was documented as being a Stage III (5).

Review of the physician's note dated 7/8/16 documented, "Left heel pressure wound being followed by NP (nurse practitioner)."

An observation of Resident #4's wound care was made on 12/7/16 at 7:55 a.m. with LPN (licensed practical nurse) #1, the wound care nurse and ASM (administrative staff member) # 5, the nurse practitioner who cared for the resident. The heel wound was cleansed as ordered. The wound measured 0.3 cm x 0.5 cm and was pink without drainage. A dry dressing was applied. During the wound care observation ASM #5, the nurse practitioner, stated, "The hospital didn't really want us to take it (Resident #4's left leg splint) off. There was no padding in the splint." When asked

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if the orthopedic doctor had been called for instructions about the care of the splint, ASM #5 stated he had not. ASM #5 stated, "It (the wound) was as big as the palm of my hand." LPN #1 also stated that there was no padding in the splint.

An interview was conducted on 12/7/15 at 1:45 p.m. with RN (registered nurse) #1, the unit manager. When asked about the process staff follows when a resident had a splint, RN #1 stated, "Make sure it's not too tight, make sure they can wiggle their toes." The nurse's notes were reviewed with RN #1. When asked if there was documentation that the splint had been removed and the skin assessed, RN #1 stated no. When asked if a fiberglass cast was a soft cast, RN #1 stated, "No." When asked if the staff should have clarified Resident #4's splint order, RN #1 did not respond.

An interview was conducted 12/7/16 at 2:15 p.m. with LPN #6. When asked how staff cares for a resident with a leg splint, LPN #6 stated, "Make sure the resident is aware of the splint, secure it, and check for circulation and for any bruises." When asked if the splints were removed, LPN #6 stated, "It depends on the order. If the order is to keep the splint in place I would still unwrap it and check for a bruise and the skin integrity. It is a device because it goes against the skin and it can cause friction. A blister could come off. As a nurse I would have to check the skin." When asked if she remembered caring for Resident #4's when she had the leg splint, LPN #6 stated, "I remember she had a splint but I don't remember exactly what it was like."

An interview was conducted on 12/7/16 at 2:45 p.m. with ASM #2, the nurse executive and LPN

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#1, the wound care nurse. When asked about the process staff follows for a resident with a leg splint, ASM #2 stated, "Anyone with a splint comes in with orders regarding the care of the splint. We have to be able to check the skin. If it (the order) says to leave it on we check the circulation, the color and the range of motion of that area." LPN #1 stated, "We know (name of Resident #4) skin was very fragile." When asked what the splint looked like, LPN #1 stated, "It was a hard cast on the bottom, then there was webroll (a thin white gauze) and an ace wrap I think." When asked if they were aware that the resident's RP did not want the orthopedic doctor involved in the resident's care ASM #2 stated, yes. When asked who was responsible for the care of the resident's splint care, ASM #2 stated, "We are." When asked if it was reasonable for a splint to be left on for nine days before the skin was inspected, ASM #2 stated, "I've seen it both ways (orders to remove splint and orders to keep splint in place)."

An interview was conducted on 12/7/16 at 5:55 p.m. with RN (registered nurse) #7, a nurse who cared for Resident #4. When asked how staff cared for a resident with a splint, RN #7 stated, "First I check to see what the orders are and if they can remove it for ADLs, (activities of daily living)." When asked what staff would do if there were no orders, RN #7 stated, "We check the circulation and check around the edge of the splint (to make sure it's not too tight." RN #7 was asked to review her nurse's note of 5/7/16 at 8:00 p.m. When asked if she had removed the resident's splint to assess the skin, RN #7 stated, "I honestly don't remember." When asked what the risk of a splint is to a resident, RN #7 stated, "Pressure and if the pressure becomes extensive

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it can become an ulcer." When asked what she would do with the splint if resident did not see the physician the following day as ordered, RN #7 stated, "I would get a clarification order."

On 12/7/16 at 6:45 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the nurse executive and ASM #3, the regional clinical quality specialist were made aware of the above concern for Resident #4.

An interview was conducted on 12/8/16 at 8:00 a.m. with ASM #2, the nurse executive, ASM #5, the nurse practitioner and LPN #1, the wound care nurse. ASM #5 stated that when the resident first came back with the splint she had talked with the daughter and she did not want the resident to be seen by the orthopedic doctor. When asked who was responsible for the care of the resident and the fracture, ASM #5 stated that she was. ASM #5 stated, "Knowing her (Resident #4's) skin history, we had to do a skin check. When we saw it we knew we had a problem." When asked why they had waited nine days to check the skin on a resident with an unpadded splint, ASM #5 stated that she had checked the x-ray again before they removed the splint. When asked if she had consulted the orthopedic doctor about the care of the splint, ASM #5 stated that she had not. When asked if she had reviewed the care with the physician she said she had. When asked if it was reasonable for this resident who had a skin history to go nine days without a skin check the staff did not respond. When asked what interventions they had in place to prevent the pressure ulcer, LPN #1 stated, "We checked her circulation. There was no drainage coming through the splint." When asked if circulation checks would indicate skin integrity, LPN #1

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stated, "No." When asked if waiting for drainage to come through a splint before checking a resident's skin integrity was routine nursing practice, LPN #1 stated it was not.

An interview was conducted on 12/8/16 at 8:25 a.m. with RN #5. When asked the process staff follows when a resident had a leg splint, RN #5 stated, "You're going to assess the extremity. Remove the splint with care; check the circulation, check to see if the resident is having any discomfort. Bathe the area, dry it thoroughly and check the skin." When asked what process if followed if there was no doctor's order for the care of the splint, RN #5 stated, "Go directly to the medical director or NP (nurse practitioner) (for orders). Send it (the order) to rehab (rehabilitation) to treat." When asked if she had cared for Resident #4 when she had the leg splint RN #5 could not remember.

An interview was conducted on 12/8/16 at 8:40 a.m. with OSM (other staff member) #8, the occupational therapist. When asked about occupational therapy's role in caring for a resident with a splint, OSM #8 stated, "It depends on what the order says. If it says remove every shift that's nursing." Resident #4's splint order was reviewed with OSM #8. OSM #8 stated, "I would contact the physician for further orders."

An interview was conducted on 12/8/16 at 9:55 a.m. with LPN #5. When asked the process staff followed when a resident had a splint, LPN #5 stated, "We check circulation, movement and sensation." When asked if the splint would routinely be removed, LPN #5 stated, "It depends, I would get a clarification on that." LPN #5 reviewed the emergency room discharge

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instructions for Resident #4 documenting that the splint was to stay in place until the following day when the resident was seen by the orthopedic doctor. When asked what she would do if the resident did not see the physician the following day as ordered, LPN #5 stated, "I would call and get a clarification order." When asked if she had cared for Resident #4 when she had the splint, LPN #5 stated she had not.

An interview was conducted on 12/8/16 at 10:10 a.m. with ASM #4, the resident's physician. When asked what he recalled about Resident #4's leg fracture, ASM #4 stated, "I know it was either from an unwitnessed fall or osteo (osteoporosis)." When asked who cared for the resident's fracture and splint care if the resident's family refused the resident to be seen by the orthopedic doctor, ASM #4 stated, "If they don't go to an ortho (orthopedic) surgeon, I would take care of it. I have extensive ortho experience." When asked how a resident's splint should be managed by the nursing staff, ASM #4 stated, they should remove the splint at least once a day. You can get a DTI (deep tissue injury) with a splint. Its good nursing." When asked if there would be a specific order to remove the splint, ASM #4 stated, "No, that's not a normal thing. A splint is a potential pressure device; anytime you develop pressure you develop a pressure wound." When asked if it was reasonable to leave a splint on for nine days before inspecting the skin, ASM #4 stated, "That would not be good. I was not aware of it." When asked if the nurse practitioner had reviewed the resident's care with him, ASM #4 stated that he reviews resident's care with his nurse practitioners and that "anyone with a splint is brought to my attention at the IDT (interdisciplinary team) meeting every Tuesday."

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On 12/8/16 at 11:30 a.m. voice mails were left with two nurses who cared for Resident #4. The nurses did not return the call prior to exit.

Review of the facilities titled, "Skin Integrity Management" documented, "POLICY. The implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed. PURPOSE. To provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds. 3. Identify patient's skin integrity status and need for prevention intervention treatment on the Center's 24-Hour Summary Report. 4. Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated. 4.1 Implement pressure ulcer prevention for identified risk factors."

The facility policy titled, "13.2 Splints, Hand Rolls, Heel Protectors, and Other Supportive/Protective Devices" documented, "POLICY: Residents are assisted as necessary by trained staff with the application and removal of preventative devices such as splints, hand rolls, heel protectors, or other supportive/protective devices as specified on the service plan. The measures/devices are provided in accordance with an order from the resident's physician. PURPOSE: To provide appropriate assistance to resident in order to promote health and well being and prevent injury or debilitation...8. Splints, braces, and other preventative/protective devices: 8.1 Wash area with soap and water; dry with towel. 8.1.1 Ensure that area to be covered is dry. 8.2 Apply device

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according to manufacturer's directions (if available) or resident/resident representative directions. 8.3 Observe and monitor for correct placement of device and resident's comfort. 8.4 Remove and replace device as outlined in the service plan. 8.5 Observe skin while applying and removing device; note any redness or other skin abnormalities. 8.7 Record date, time applied, time removed, and any observed problems in logbook..."

No further information was provided prior to exit.

(1) Deep Tissue Injury -- Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). This information was obtained from: http://www.npuap.org/resources/position-statements/
(2) Granulation tissue -- If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). This

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information was obtained from:
http://www.npuap.org/resources/position-statements/
(3) Eschar -- If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). This information was obtained from:
http://www.npuap.org/resources/position-statements/
(4) Slough -- The presence of non-viable tissue in a chronic wound presents a barrier against effective wound healing, hence removal facilitates healing and reduces areas where microorganisms can attach and form biofilms, effectively reducing the risk of infection. Wound debridement is a necessary process in those wounds that have evidence of cellular debris and non-viable tissue. As slough is a form of non-viable tissue we hypothesise that it will support the attachment and development of biofilms. Biofilms are entities that have serious implications in raising the risk of infection and delaying wound healing. In those wounds that contain only slough, high-risk debridement methods are not considered necessary for its removal. This information was obtained from:
https://www.ncbi.nlm.nih.gov/pubmed/26551642

(5) Stage III -- Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.

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If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. This information was obtained from: http://www.npuap.org/resources/position-statements/

2. On 8/4/16 Resident #10's orthopedist wrote an order for an ankle clam shell brace. The facility staff failed to seek clarification regarding removal of the brace and skin assessments for the area underneath the brace. A skin assessment dated 8/16/16 documented a deep tissue injury (1) on the resident's right inner ankle and a stage two pressure ulcer (1) on the resident's right outer ankle.

Resident #10 was admitted to the facility on 6/25/16. Resident #10's diagnoses included but were not limited to: displaced ankle fracture of the right lower extremity, chronic kidney disease and heart failure. Resident #10's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 9/19/16, coded the resident's cognition as being severely impaired. Section G documented the resident required extensive assistance of one staff with bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene and bathing. Section M documented Resident #10 presented with two unstageable pressure ulcers (1) due to non-removable dressing/device.

A Braden scale for predicting pressure sore risk dated 7/16/16 documented Resident #10 was at mild risk for pressure ulcer development. The form documented the resident's sensory perception was slightly limited, the resident's skin was occasionally moist, the resident was chair

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fast, the resident's mobility was slightly limited, the resident's nutrition was adequate and the resident presented with a potential problem regarding friction and shear.

An orthopedist consult note dated 8/4/16 documented, "S/P (Status post) ORIF (open reduction internal fixation [surgical procedure]) Right ankle fx (fracture). Skin intact, incisions well-healed...Recommendations: Weight bearing as tolerated with walker and assistance/observation at all times. Fall Risk. 2. Wear ankle clam shell/ (illegible word) brace at all times. Wear thick sock underneath at all times to protect skin..." The brace was discontinued on 8/24/16.

A physician's order dated 8/4/16 documented, "Weight bearing as tolerated with walker & (and) assistance /observation at all times. Wear ankle clam shell brace at all times, wear thick sock underneath-protect skin. F/U (follow up) in 4 wks (weeks)."

A nurse's note dated 8/4/16 documented, "Weight bearing as tolerated with walker and assistance observation at all times while weight bearing. F/u (follow up [with the orthopedist]) in 4 weeks, wear ankle clam shell brace at all times, wear thick sock underneath to protect skin. RP (Responsible party) aware."

A nurse's note dated 8/6/16 documented, "Action/nursing interventions: patient is a total assist with all ADLs (activities of daily living). patient (sic) is incontinent of B&B (bowel and bladder). No c/o (complaint of) pain or distress at this time. soft (sic) brace to the right RLE (right lower extremity) remains intact..."

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A nurse's note dated 8/9/16 documented, "A skin check was performed. No skin injury/wound(s) were noted."

A "skin check" form dated 8/9/16 documented, "Skin Check Performed. 1. Skin Injury/Wound(s) Identified- No. 4. External devices (cast/prosthetic, brace) present- No."

Review of nurses' notes from 8/4/16 through 8/16/16 failed to reveal any further documentation regarding Resident #10's brace, removal of the thick sock and/or skin checks.

Resident #10's August 2016 TAR (treatment administration record) documented, "6/30/16- Check CMS (circulation, motion and sensation) on right lower extremity every shift." The TAR further documented, "8/4/16- Wear ankle clam shell brace at all times, wear thick sock underneath- protect skin." The TAR failed to document the thick sock was being removed.

A physical therapy progress report for the dates of service from 8/5/16 through 8/18/16 and signed on 8/19/16 documented, "Precautions/Contraindications: WBAT (weight bearing as tolerated), R ankle brace, Fall risk..." The report failed to document any further information regarding Resident #10's brace or any information regarding the resident's skin underneath the brace.

Occupational therapy notes dated 8/5/16 through 8/16/16 documented, "Precautions/Contraindications: WBAT RLE (right lower extremity), to wear clam shell with heavy sock underneath at all times..." The notes further

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documented the resident required assistance to manage the right ankle clam shell brace. The notes did not specify the type of assistance required. A note dated 8/10/16 documented the resident was able to doff socks, complete lower body bathing and don socks. A note dated 8/12/16 documented the resident was able to doff socks, bathe down to the feet and don socks. The notes dated 8/5/16 through 8/16/16 failed to document information regarding skin assessments for the skin underneath the sock and clam shell brace. The notes from 8/12/16 to 8/16/16 failed to document any information regarding removal of socks.

Resident #10's comprehensive care plan initiated on 7/5/16 and active during the time period of 8/4/16 through 8/16/16 documented, "Resident is at risk for skin breakdown as evidenced by limited mobility, incontinence...Weekly skin assessment by license nurse..." The care plan failed to document any information regarding the resident's clam shell brace.

A "skin check" form dated 8/16/16 documented, "Skin Check Performed. 1. Skin Injury/Wound(s) Identified- Yes. 2. New Skin Injury/Wound(s) Identified- Yes. 3. Previously Noted Skin Injury/Wound(s) Recorded- No. 4. External devices (cast/prosthetic, brace) present- Yes. 4a. External Device(s) - removable. 5a. External device removed and site inspected. 5b. Describe area beneath device- R (Right) foot with DTI (deep tissue injury) to outer and inner ankle. Scant amount of clear D/C (discharge) noted. R foot also dry and scaly..."

A nurse's note dated 8/16/16 documented, "A skin check was performed. The following New skin

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injury/wound(s) were identified: Rash(s): Description: Fungal rash to Groin. External device removed and site inspected: R foot noted with DTI to outer and inner ankle, scant amount of clear D/C noted, R foot also dry and scaly, removable."

A skin integrity report initiated on 8/16/16 documented:
"Circle Primary Type of Wound- (a circle was documented around the word 'Pressure'). Anatomical Location- R inner ankle. Initial Wound Date: 8/16/16. Initial Stage: DTI. Appearance: IP- Intact/Deep purple. Length (cm [centimeters]) 1.0. Width (cm) 1.0..." A physician's order dated 8/16/16 documented an order to cleanse the area with normal saline, pat dry and apply a dry clean dressing daily. Note: according to the skin integrity report, this area remained a DTI on 8/18/16 but the treatment was changed to include medihoney (2). On 8/31/16 the area declined to an unstageable pressure ulcer measuring 1.0 cm length by 1.0 cm width. The area healed on 11/4/16.

Another skin integrity report initiated on 8/16/16 documented:
"Circle Primary Type of Wound- (a circle was documented around the word 'Pressure'). Anatomical Location- R outer ankle. Initial Wound Date: 8/16/16. Initial Stage: II. Appearance: 100% G (Granulation). Length (cm) 1.5. Width (cm) 1.0..." A physician's order dated 8/16/16 documented an order to cleanse the area with normal saline, pat dry and apply a dry clean dressing daily. Note: according to the skin integrity report, this area remained a stage two pressure ulcer on 8/18/16 but the treatment was changed to include medihoney. On 8/31/16 the

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area declined to an unstageable pressure ulcer measuring 2.0 cm length by 1 cm width. The area healed on 11/4/16.

On 12/7/16 at 10:34 a.m., an interview was conducted with LPN (licensed practical nurse) #1 (the wound care nurse). LPN #1 was asked if a resident's brace should be removed to assess the skin underneath. LPN #1 stated it depended on what the physician ordered and varied for each patient. LPN #1 was asked what should be done if there was no order to remove the brace. LPN #1 stated the nursing staff would call the physician and get one.

On 12/7/16 at 2:25 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe what should be done if a resident with an ankle fracture returns from the orthopedist office and has no specific orders to assess the skin underneath the brace. RN #1 stated if there was no order then she would call the physician's office to find out what they wanted and get an order in place.

On 12/7/16 at 3:42 p.m., an interview was conducted with ASM (administrative staff member) #2 (the nurse executive) and LPN (licensed practical nurse) #1 (the wound care nurse). LPN #1 stated on 8/4/16, Resident #10 went to the orthopedist who ordered a clam shell air splint. LPN #1 stated the orthopedist wrote an order for a sock to be placed under the clam shell air splint to protect the skin. LPN #1 stated on 8/16/16, a skin check was performed, pressure ulcers were identified and treatment was initiated. LPN #1 stated on this day (12/7/16), she called the orthopedist and received clarification to remove the clam shell brace and sock daily to

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perform skin checks. LPN #1 stated at the time the brace was ordered, the orthopedist took for granted that facility staff would perform daily skin assessments under the brace and no order was written. LPN #1 presented the orthopedist order dated 12/7/16 that documented, "Remove ankle brace/sock daily to perform skin checks. Place sock and brace back on ankle when complete." (Note- at this time, the clam shell brace had already been discontinued and was not in place). At this time, ASM #2 and LPN #1 were asked to provide evidence that Resident #10's skin underneath the brace was being assessed from 8/4/16 through 8/16/16. ASM #2 stated nurses were performing weekly skin checks. ASM #2 was made aware the last documented skin assessment (prior to 8/16/16 when the pressure ulcers were found) was on 8/9/16. ASM #2 was made aware on 8/9/16, the nurse documented no skin concerns but also documented the resident did not have a brace. ASM #2 was asked to provide evidence that Resident #10's skin underneath the brace was assessed within the last few days prior to 8/16/16. ASM #2 stated she could identify who worked with the resident during those days and obtain statements. ASM #2 was made aware this surveyor would need to speak with those nurses.

On 12/7/16 at 6:45 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 were made aware of the above findings and the concern for harm. ASM #1 and ASM #2 were asked to provide any further information in the morning.

On 12/8/16 at approximately 8:00 a.m., ASM #2 was asked to provide nurses who cared for Resident #10 during the days leading up to

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F 314	Continued From page 77 8/16/16 On 12/8/16 at 8:23 a.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked to describe care that should be provided to residents who have a lower extremity brace. RN #5 stated she assesses the extremity, removes the splint with care, assesses the resident's circulation, capillary refill, discomfort, and makes sure the skin has moisture, no dryness and no pressure. RN #5 stated she would also check for the times when the brace should be on or off and instructions to staff members who provide direct care. RN #5 was asked how often she would perform these assessments. RN #5 stated it depended on how she was instructed to do so but it could be with morning and afternoon care. RN #5 was asked what should be done if there were no instructions. RN #5 stated she would go directly to the physician/nurse practitioner, find out instructions, assess the consult recommendations and check with the rehab department. RN #5 stated her interpretation was that the rehab department gets consults for devices so she would give the orders to the rehab (rehabilitation) department or talk with them. RN #5 stated the nursing department conducts scheduled skin checks and CNAs (certified nursing assistants) report any abnormal skin concerns to the nurses. RN #5 stated it was an unspoken nursing practice to assess the skin underneath a brace but if the order regarding the brace was unclear she would put a note in the nurse practitioner's book. At this time, RN #5 was read Resident #10's clam shell brace order dated 8/4/16 and asked if she would remove the brace to assess the skin underneath. RN #5 stated she would think nursing staff would need to clarify the order.	F 314		

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The certified occupational therapy assistant who worked with Resident #10 was unavailable for interview during survey. The occupational therapist who primarily worked with Resident #10 was no longer employed at the facility. On 12/8/16 at 8:40 a.m., an interview was conducted with OSM (other staff member) #8 (another occupational therapist who worked with the resident). OSM #8 was asked to describe her role in the care of a resident who wore a lower extremity brace in regards to skin assessments. OSM #8 stated it depended on what the order said. OSM #8 stated she thought if the order documented to remove the brace every shift for skin checks then the nursing staff would be responsible for doing so. OSM #8 stated sometimes the orders documented to not remove the brace until follow up with the physician. OSM #8 stated she bases her care on what the order documents. OSM #8 was made aware of Resident #10's 8/4/16 order. OSM #8 stated, "It doesn't even say remove for hygiene. It doesn't say skin checks. It just says wear at all times. It doesn't clarify." OSM #8 stated a lot of times; the occupational therapists will get a copy of brace orders because they work with residents on bathing and dressing. OSM #8 stated the order documented to wear the brace at all times so she would hesitate to remove the brace. OSM #8 stated a lot of times she would write notes and ask the physician for clarification.

On 12/8/16 at 9:52 a.m., an interview was conducted with LPN #5. LPN #5 was asked to describe care that should be provided for residents with a lower extremity brace. LPN #5 stated each shift, the resident's toe color, skin temperature and movement should be assessed.

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LPN #5 stated the nurse should also look for skin breakdown. LPN #5 was asked if she would remove the brace to assess the skin underneath. LPN #5 stated, "It depends. I would have to get clarification." LPN #5 stated sometimes braces are not supposed to be removed so she would call the physician and get clarification. LPN #5 was asked to describe a clam shell brace. LPN #5 stated a clam shell brace was made of two pieces that sealed together. LPN #5 stated if the physician had not documented to remove the brace then she would call the physician and would not assume the brace could be removed.

On 12/8/16 at 10:08 a.m., an interview was conducted with ASM #4 (Resident #10's attending physician). ASM #4 stated he had an orthopedic background because he had previously worked at an orthopedic hospital for many years. ASM #4 was asked to describe the care that should be provided to a resident with a lower extremity brace. ASM #4 stated the brace should be removed once a day or at least 48 hours to make sure there is no redness of the skin under the brace. ASM #4 stated residents with braces can sustain tissue injuries. ASM #4 stated braces cause pressure and create a potential for pressure ulcers so it's good for nursing staff to assess the skin underneath the brace.

On 12/8/16 at 10:29 a.m., this surveyor attempted to call Resident #10's consulting orthopedist's nurse. The nurse did not answer the phone.

On 12/8/16 at 10:34 a.m., an interview was conducted with LPN #1 (the wound care nurse). LPN #1 stated she had spoken to Resident #10's consulting orthopedist's nurse on 12/7/16. LPN #1 stated she explained to the nurse that this

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surveyor was at the facility and was looking at the orthopedist's progress note regarding the sock and brace. LPN #1 stated she asked the orthopedist's nurse if the brace was supposed to be removed for skin checks and the nurse stated yes the brace was supposed to be removed for skin checks but not written on the order because the orthopedist took for granted that the facility nurses would do so.

On 12/8/16 at 3:40 p.m., another interview was conducted with LPN #1 (the nurse who signed off a CMS check for Resident #10 during the day shift on 8/15/16). LPN #1 stated on 8/15/16 she checked Resident #10's capillary refill, made sure the resident could move her toes and made sure the resident was not experiencing pain. LPN #1 confirmed she did not remove the resident's clam shell brace because there was no physician's order to do so.

On 12/8/16 at 3:44 p.m., this surveyor attempted to call the nurse who cared for Resident #10 on the 11:00 p.m. to 7:00 a.m. shift beginning on 8/15/16 into 8/16/16. The nurse did not answer the phone.

On 12/8/16 at 3:45 p.m., this surveyor attempted to call the nurse who cared for Resident #10 on the 3:00 p.m. to 11:00 p.m. shift on 8/13/16 and 8/14/16. The nurse also cared for the resident during the 7:00 a.m. to 3:00 p.m. shift on 8/14/16. The nurse did not answer the phone.

Another nurse that cared for Resident #10 on 8/13/16, 8/14/16 and 8/15/16 was unavailable for interview.
Another nurse that cared for Resident #10 on 8/16/16 was no longer employed at the facility.

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On 12/8/16 at 3:48 p.m., ASM #1 was made aware the above nurses did not answer the phone.

The facility policy titled, "13.2 Splints, Hand Rolls, Heel Protectors, and Other Supportive/Protective Devices" documented, "POLICY: Residents are assisted as necessary by trained staff with the application and removal of preventative devices such as splints, hand rolls, heel protectors, or other supportive/protective devices as specified on the service plan. The measures/devices are provided in accordance with an order from the resident's physician. PURPOSE: To provide appropriate assistance to resident in order to promote health and well being and prevent injury or debilitation...8. Splints, braces, and other preventative/protective devices: 8.1 Wash area with soap and water; dry with towel. 8.1.1 Ensure that area to be covered is dry. 8.2 Apply device according to manufacturer's directions (if available) or resident/resident representative directions. 8.3 Observe and monitor for correct placement of device and resident's comfort. 8.4 Remove and replace device as outlined in the service plan. 8.5 Observe skin while applying and removing device; note any redness or other skin abnormalities. 8.7 Record date, time applied, time removed, and any observed problems in logbook..."

No further information was presented prior to exit.

"Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an

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F 314	Continued From page 82 open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue... Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions)... Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed... Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon,	F 314		

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F 314	Continued From page 83 purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (2) Medihoney is medical grade honey used in the treatment of wounds. This information was obtained from the website: http://www.dermasciences.com/medihoney	F 314		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334	1. Resident #5 was given the influenza vaccine on 12/10/16. 2. A review of resident records was completed by the Nurse Practice Educator (NPE), to confirm each record had evidence of either a signed consent or declination for a vaccination, and if a resident did consent they did receive the vaccination. No other residents were affected by this deficient practice.	

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F 334	Continued From page 84 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 334	3. Nursing staff on all shifts will receive re-education by the CNE/designee on influenza /pneumococcal vaccination policy and procedure. 4. The CNE/designee will conduct random, monthly audits to determine compliance regarding residents, or their RP, receiving timely notification and education regarding the vaccine, and those who consent do receive the vaccine in a timely manner. Results of the audit will be reviewed at the monthly QA Committee meeting x3 months.	1/21/17

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F 334	Continued From page 85 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to offer the influenza vaccination to one of 26 residents in the survey sample, Resident #5. Facility staff failed to follow up with the responsible party regarding consent for the influenza vaccine for Resident #5. The findings include: Resident #5 was admitted to the facility on 3/2/2011 and readmitted on 9/9/16 with diagnoses that included but were not limited to type two diabetes, unspecified dementia without behavioral disturbance, muscle weakness, difficulty in walking, hypertension, osteoporosis, breast cancer, heart failure, and hypothyroidism. Resident #5's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 11/22/16. Resident # 5 was coded as being cognitively	F 334		

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impaired in the ability to make daily decisions scoring 07 out of 15 on the BIMS (brief interview for mental status) exam. Resident #5 was coded as requiring extensive assistance from two plus staff members with transfers, bed mobility, toileting, bathing, and locomotion off the unit.

Review of Resident #5's most recent MDS with an ARD of 11/22/16 documented the following under Section O0250. Infuenza Vaccine: "Did the resident receive the influenza vaccine in this facility for this year's influenza season?"

A "0" (zero) was coded indicating that the influenza vaccine was not received.

Part C of Section O0250. documented the following: "If influenza vaccine not received, state reason"

A "5" was coded indicating that the vaccination was "Not Offered".

Review of Resident #5's clinical record revealed a family consent letter that documented the following: "It is time for our annual Influenza Vaccination Program. This program is designed to prevent the spread of influenza and its severe complications to our patients. In order to administer the vaccine to the patient, we need permission. Please review the enclosed information sheet titled, "Influenza Vaccine Information Statement." After reading the information sheet, complete the Influenza Informed Consent form by signing your name in the bottom if the form. Please return the form by October 14, 2016..."

No follow up with the RP (responsible party) could

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F 334	Continued From page 87 be found regarding the influenza vaccination. There was no evidence that the influenza vaccination was administered. On 12/7/16 at 3:19 p.m., an interview was conducted with RN (registered nurse) #2, the nurse responsible for the infection control program. RN #2 stated that Resident #5 was a readmission so she had sent a letter to the family on 10/7/16 about the flu vaccine along with a consent form. RN #2 stated that she did not follow up with the family when the October 14th deadline passed. RN #2 stated, "I should have followed up." On 12/7/16 at 6:45 p.m., ASM (Administrative staff member) #1, the administrator and ASM #2, the Director of Nursing were made aware of the above concerns. No further information was presented prior to exit. The facility policy requested was not provided.	F 334		
F 364 SS=B	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to serve food in a palatable manner.	F 364	1. For residents that were affected during these meal passes, staff offered to warm the food at the time it was delivered. Some residents accepted the offer, some declined. 2. Multiple residents could be affected by this deficient practice. 3. The Food Services Director (FSD/designee will: Ensure that food temperatures are achieved consistent with all recipe directions, monitor & record food temps before tray line starts to ensure proper holding temperatures, and re-educate	

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F 364	Continued From page 88 Facility staff failed to serve food at a palatable temperature. The findings include: On 12/6/16 at 2 p.m., a group interview was conducted with seven cognitively intact residents. Most residents stated that food was cold when it was served to them on the hallways. On 12/6/16 at 5:15 p.m., observation of tray line was conducted. The following food items and temperatures were recorded on tray line (degrees Fahrenheit). 1. Brussels sprouts- 140 2. Maple cranberry turkey- 180 3. Potatoes- 150 4. Green beans- 160 5. Advanced potatoes- 140 6. Puree bread- 160 7. Puree potatoes-160 8. Puree green beans-150 9. Fish- 170 On 12/6/16 at 6: 30 p.m., the test tray was conducted. The following food items and temperatures were recorded (degrees Fahrenheit). 1. Brussels sprouts- 98.8 2. Maple cranberry turkey-100.6 3. Potatoes- 100.9 4. Green beans-101.1 5. Puree bread-106.0 6. Puree green beans-107.2 On 12/6/16 at approximately 6:35 p.m., an	F 364	department staff on recording temps and calibrating thermometers per facility policy. During survey, Regional FSD ordered new domes and undershields with a higher temperature-retaining rating. 4. Tray assessments will be conducted 3 times per week, one for each meal (breakfast, lunch and dinner). Results of these assessments will be shared at the monthly QA Committee meetings until x3 months.	1/21/17

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interview was conducted with OSM (other staff member) #10, the dietary manager and OSM #11, the Regional Dietary Manager. When asked what they thought of the food after tasting a sample of the test tray, OSM #10 stated, "Ya, it is cold." When asked what they would consider a palatable temperature, OSM #11 stated usually 120 degrees Fahrenheit or above. When asked if resident's have ever complained about the temepratures of the food, OSM #10 stated, "Complained in the past, yes." When asked how they resolved these complaints of cold food, OSM #11 stated that the facility should be doing a tray assessment every week. When asked if he could provide evidence of a test tray assessment, OSM #11 stated, "I will have to check."

On 12/7/16 at approximately 6:45 p.m., ASM (administrative staff member) #1, the Administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concern.

OSM #11 could not provide evidence that a test tray assessment was being completed every week.

Facility policy titled, "Food handling" documents in part, the following: "All time/temperature control for safety food must maintain an internal temperature of 41 degrees Fahrenheit or lower, or 135 degrees Fahrenheit or higher while being held for service...During transportation of food from the kitchen to the dining rooms, patient/resident rooms, or other dining locations, care is taken to keep hot food hot and cold food cold and protected from contamination...For point of service temperatures or Time/Temperature Control for Safety food, refer to the Food and Drug Administration's (FDA's) Food Code."

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F 364	Continued From page 90 No further information was presented prior to exit.	F 364		
F 371 SS=E	Complaint Deficiency 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined that facility staff failed to store food in a sanitary manner. Facility staff failed to ensure the facility's kitchen	F 371	1. No residents were affected by the deficient practice. 2. Multiple residents could be affected by this deficient practice. 3. The Food Services Director (FSD) will ensure that: Produce is inspected for quality upon receipt, product out-of-date are discarded, all opened items are date-labeled per policy, a "Use by Date" guide is posted in all production areas, and dietary staff is re-inserviced on proper labeling and dating of product. 4. FSD/designee will monitor product labeling and dating on a daily basis for compliance, with results shared at the monthly QA Committee meetings x3 months.	1/21/17

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refrigerator was free from expired food items.

The findings include:

On 12/6/16 at 11:10 a.m., inspection of the kitchen was conducted. At 11:13 a.m., inspection of the kitchen refrigerator was conducted. The following items were observed to be expired:

1. Cultured sour cream with an expiration date of 12/3/16. No open date was labeled on the container.
2. A box full of fat free wholesome skim milk with an expiration date of 12/3/16.
3. One rotted lemon that appeared to be growing mold was observed in a container full of lemons.
4. Two zip lock bags of shredded carrots were observed with no open date or expiration date labeled on the bags. The carrots appeared to be rotten with cloudy liquid in the bags.
5. One zip lock bag of ham was observed with no open or expiration date.

On 12/6/16 at 11:13 a.m., an interview was conducted with OSM (other staff member) #3, the cook. When asked the expiration date of the sour cream, OSM #3 agreed that the expiration date was labeled 12/3/16. When asked how often the kitchen refrigerator was checked for expired food items, he stated, "Well technically we throw things out seven days after expiration. I try to throw things away three days after expiration." When asked when the sour cream was opened, OSM #3 stated that he was not sure. OSM #3 stated, "I open things like this up to see if it still good, and this is still good. When it was opened, I don't know." OSM #3 stated an open date should have been written on the sour cream container. OSM #3 stated, "I am trying to

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hurry up and label things now."

On 12/6/16 at 11:15 a.m. a further interview was conducted with OSM #3. When asked what was in the two zip lock bags full of shredded carrots, OSM #3 stated, "Trash. I believe these are carrots but they are trash now." When asked how old the carrots were, OSM #3 stated that he was not sure because there was no date on the zip lock bag. When asked if there was a date labeled on the zip lock bag full of ham identifying when it was placed in the bag, OSM #3 stated that there was no date labeled. OSM #3 stated that the ham had just been put in the refrigerator the day before but someone forgot to label the bag. OSM #3 stated that the bag should have been labeled.

On 12/8/16 at approximately 9:00 a.m., an interview was conducted with OSM (other staff member) #11, the Regional Dietary Manager. When asked who was responsible for checking the facility's refrigerator for expired food items, OSM #11 stated that the entire kitchen staff was responsible. When asked when he would throw away food items, OSM #11 stated, "It depends on the food. If it has an expiration date, we would throw it away when it expires. If it's something like oranges, we would have to get a visual." When informed about the above expired food items, OSM #11 stated that even though the milk was expired, the kitchen will still use the milk for cooking. OSM #11 also stated that the zip lock bag full of ham with no open date or use by date was still fresh; the bag was just not labeled. OSM #11 stated, "It was just put in there and we didn't get a chance to label."

On 12/7/16 at approximately 6:45 p.m., ASM

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F 371	Continued From page 93 (administrative staff member) #1, the administrator and ASM (administrative staff member) #2, the DON (Director of Nursing) was made aware of the above findings. Facility policy titled, "Food Handling" documents in part, the following: " Foods that are marked with the manufacturer's "use by" date that are properly stored can be used until that date as long as the product has not been combined with any other food or prepared in any way including portioning." The facility policy did not address expired produce. Facility policy titled, "Refrigerated/Frozen Storage" documented in part, the following: "Food is dated when received and with "use by" date when opened. Manufacturer use by dates are used until opened...Foods are kept in the original container. If removed from the original container, foods are completely covered and labeled with name of product and "use by" date." No further information was presented prior to exit.	F 371		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the	F 425	1. Resident #26 is no longer in the facility. 2. CNE/designee reviewed resident records to determine timely management of pain. No other residents were affected by this deficient practice. 3. The Admissions Department will identify whether pain management is required for any re-admissions or new admissions, that these individuals receive the pain	

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F 425	Continued From page 94 provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that facility staff failed to ensure medications were available for one of 26 Residents in the survey sample, Resident #26. The facility staff failed to ensure Norco (1) 7.5/325 mg (milligram) tablet was available for administration as ordered by the physician for Resident #26. The findings include: Resident #26 was admitted to the facility on 3/11/16 with diagnoses that included but were not limited to aftercare following joint replacement surgery, presence of right artificial hip joint, osteoarthritis, high blood pressure, high cholesterol, anemia, major depressive disorder, and anxiety disorder. Resident #26 most recent MDS (minimum data set) assessment was a five day scheduled assessment with an assessment reference date of 3/16/16. Resident #26 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (brief interview for mental status exam). Resident #26 was coded as requiring supervision with transferring, walking, dressing, toileting, personal hygiene, and bathing; and independent with meals and locomotion. Review of Resident #26's most recent POS (physician order sheer) revealed the following order: "Hydrocodone-Acetaminophen (Norco) 7.5 mg/325 mg (milligrams) 1-2 tabs (tablets) PO (by mouth) every four hours prn (as needed) pain."	F 425	medication prior to transfer to the facility, and the individual arrives at the facility with a corresponding physician order so that the medication can be requested immediately by the admitting nurse from the pharmacy. All new admissions will be assessed for pain behaviors using pain assessment and their pain managed appropriately. The pharmacy will be immediately notified by the admitting nurse whenever an ordered medication is not available in the stat box. Nursing staff on all shifts will be re-educated by the CNE/designee on the policy Pain Management. 4. CNE/designee will regularly review the stat box with the pharmacy representative, and review all admissions and provide timely procurement of medications so that the resident has an easy transition An audit will be conducted by the CNE/designee specific to timely pain management, with pro-active measures to minimize pain will be addressed daily. Results of these audits will be reviewed at the monthly QA Committee	1/21/17

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This order was clarified on 3/14/16 to the following: "Give 1 Norco 7.5/325 mg po q 4 hours prn mild to moderate pain...Give 2 Norco 7.5/325 mg po q (every) 4 hours prn mod (moderate) to severe pain."

Review of the nursing notes revealed the following note dated 3/16/16 at 1:06 a.m.: "Pt (patient) became very upset about pain medication. Pharmacy contacted, and pain medication was re-ordered and reported to be delivered stat. This nurse went to patient and offered non-pharmacological pain interventions until Norco arrived from pharmacy. Pt (patient) requested an ice pack and to lie in bed. Ice pack provided to patient and pt assisted into reclining position in bed. This nurse offered to contact to contact the physician and request either Tylenol or ibuprophen on her behalf. Pt denied offer stating, "If I take that now, I won't be able to take the Norco when it gets here. I will just wait." Pt placed her c-pap mask on and stated "I'll just try to relax. Please bring me my medicine when it gets here."

Review of the narcotic log revealed that Resident #26's last dose of Norco was on 3/15/16 at 5 p.m. A pain score was not documented. A note documenting pain medication effectiveness was not found.

Further review of the narcotic log for Norco 7.5/325 mg revealed that Resident #26 did not receive her Norco until 3:40 a.m. on 3/16/16. A pain score was not documented when she received her medication. A note could not be found documenting pain medication effectiveness.

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Review of the facility's emergency stat (Immediate) box revealed that Norco 7.5 /325 mg was not available in the stat box.

On 12/8/16 at 9:04 a.m., an interview was conducted with LPN (licensed practical nurse) #9, a nurse who worked with Resident #26. When asked about the process staff follows for refilling resident pain medications, LPN #9 stated that nursing staff should refill pain medications before it runs out. LPN #9 stated that she waits until 10 or 12 tablets are left in the package before she will refill the medication. LPN #9 stated that it is never ok to run out of pain medication especially if they are narcotics. LPN #9 stated that issues can arise with narcotics further delaying the refill process such as pharmacy needing a hard script. LPN #9 stated that if a resident does run out of pain medication, the physician must be notified to get an alternative medication.

On 12/8/16 at 9:37 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated that Resident #26's Norco was not available because the facility did not have a hard script. ASM #2 stated that the resident had a history of drug seeking behavior.

On 12/8/16 at 10:06 a.m., an interview was conducted with RN (registered nurse) #4. RN #4 stated that she refills medications three days before it runs out. RN #4 stated that if a resident runs out of pain medication she would call pharmacy and have them STAT (Immediate) out the medication. RN #4 stated that she will also call pharmacy to obtain a code to get the medication out of the STAT box. When asked

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about the process staff follows if the medication is not in the STAT box, RN #4 stated, "I would call the MD (medical doctor) for a different prescription." RN #4 could not recall the above allegation.

On 12/8/16 at 10:17 p.m., an interview was conducted with LPN #8, a nurse who was familiar with Resident #26. LPN #8 stated that he would refill a medication when about 6 pills are left in the package. He stated that sometimes pharmacy will require a hard script for pain narcotics so it is important to refill these medications right away.

On 12/8/16 at 11:11 a.m., an interview was conducted with RN #6, the nurse who worked the shift when Resident #26's pain medication ran out. RN #6 stated that she will usually re-order pain medication three days prior to the medication running out. RN #6 stated that night (3/16/16) pharmacy was stating that they did not have the original prescription for Resident #26's Norco and could not refill the medication. Resident #26 tried explaining to pharmacy that this medication was refilled before, so they must have the original prescription. RN #6 stated that she offered Resident #26 alternative pain medications until she could work out the issue with pharmacy, but the resident declined. RN #6 could not explain why the facility staff waited until the medication was out before it was refilled. RN #6 stated that her Norco ran out on her shift when she went to go give it.

On 12/8/16 at 12:02 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

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F 425	Continued From page 98 Facility policy titled, "Reordering, Changing, and Discontinuing Orders" did not address when to refill medications or the process when medications are not available on the unit. No further information was presented prior to exit.	F 425		
F 502 SS=D	Complaint deficiency 483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) 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, it was determined that facility staff failed to obtain a laboratory specimen per the physician's order for one of 26 residents in the survey sample, Resident #3. The facility staff failed to obtain clostridium difficile (c. dif) [1] specimen ordered by the physician on 8/22/16 for Resident #3. The findings include: Resident #3 was admitted to the facility on 6/6/16 with diagnoses that included but were not limited to: arthritis, high blood pressure, kidney disease, anxiety and obesity. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment	F 502	1. Resident #3 had a physician order for a stool specimen that was not obtained. No evidence of c-diff has been documented on this resident; formed stools were noted after the order was written. The resident was not diagnosed with c-diff infection. 2. Review of resident records was conducted to determine if the deficient practice affected other residents. None were identified. The administration of lab services was reviewed by the NPE, with deficient practices corrected. 3. Nursing staff on all shifts will be re-educated by CNE/designee on the facility policy specific to physician orders, laboratory services and diagnostic tests. 4. Laboratory process and documentation will be audited daily for accuracy by the Nurse Unit Managers and Supervisors. Results of the audits will be reviewed at the monthly QA Committee meetings x6 months.	1/21/17

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F 502	Continued From page 99	F 502		

reference date) of 10/31/16 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating once the tray was set up.

Review of the physician's orders dated and signed on 8/22/16 at 4:00 p.m. documented, "Collect stool sample to check for c-diff."

Review of the August 2016 medication administration record documented, "8/22 (2016) Stool for C-diff."

Review of the nurse's notes dated 8/22/16 at 11:10 p.m. documented, "Order received to collect stool sample for c-dif, due to resident had loose BM x2."

Review of the clinical record did not evidence documentation of the laboratory result.

On 12/7/16 at 6:45 p.m. a request was made to ASM (administrative staff member) #2, the nurse executive, for Resident #3's c-diff specimen results.

On 12/8/16 at 12:15 p.m. ASM #2 stated, "It (the c-diff specimen) was not done because we had a nurse who did not follow through. I checked and the resident had two formed stools after that."

An interview was conducted on 12/8/16 at 2:58 p.m. with LPN (licensed practical nurse) #5. When asked about the process staff follows when a physician orders a laboratory specimen, LPN #5 stated, "You pull the order and put it into the

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	495246	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

(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 502	Continued From page 100 computer. You transcribe it to the lab (laboratory) MAR (medication administration record) and let the RP (responsible party) know and you make a note." When asked how staff knew if a specimen had been collected, LPN #5 stated, "Usually the 11 to 7 (11:00 p.m. to 7:00 a.m.) shift will let us know." When asked if it was important to obtain a c-diff specimen, LPN #5 stated, "Yes we're very concerned for contamination." Review of the facility's policy titled, "Diagnostic Tests" documented, "POLICY. Diagnostic tests -- including laboratory....will be performed as ordered. Laboratory services will be available on-site seven days a week, 24 hours a day..." PURPOSE. To monitor patient's medical condition and therapeutic response." No further information was obtained prior to exit. [1[Clostridium difficile -- Clostridium difficile, or more commonly "C. diff," is a nasty bacterium that claims the lives of 14,000 Americans every year. Most at risk are people with conditions requiring prolonged use of antibiotics, which have the unfortunate side effect of wiping out the natural, good bacteria in the colon-thus allowing bad bugs like C. diff to multiply unchecked.	F 502		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 514	1. Resident #8 had another resident's lab results filed in their chart. It was corrected during the survey. 2. A review of resident charts was conducted to determine if other residents were affected by this deficient practice. None were identified. 3. CED/designee will confirm the	

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F 514	Continued From page 101 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility failed to maintain a complete and accurate clinical record for one of 26 residents in the survey sample, Resident #8. For Resident #8, the facility staff filed laboratory results for another resident on his clinical record. The findings include:	F 514	filing system used, the individuals responsible for filing (e.g., medical records/health information coordinator), and identify potential gaps in the system that can potentially lead to a deficient practice. 4. Chart checks completed by the nurses must include a review of actual documents in the individual charts to ensure accurate filing of information. Random chart audits will be conducted by the CNE/designee to determine compliance. Results of the audits will be reviewed at the monthly QA Committee meetings x6 months.	1/21/17

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F 514	Continued From page 102	F 514		

Resident #8 was most recently readmitted to the facility on 9/27/16 with the diagnoses of but not limited to bladder cancer, atrial fibrillation, high blood pressure, benign prostate hypertrophy, arthritis, Alzheimer's disease, psychosis, apraxia, dysphagia, lymphalytic leukemia, encephalopathy, and congestive heart failure.

The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 10/4/16. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, eating, and hygiene, and was coded as incontinent of bowel and as having a catheter for bladder.

A review of the clinical record revealed a urine culture test results for which the resident did not have an order for. Further investigation revealed this lab result was actually for another resident and was misfiled on Resident #8's clinical record.

On 12/7/16 at approximately 5:00 p.m., LPN #1 (Licensed Practical Nurse) stated that it was misfiled and should not be on Resident #8's record.

On 12/7/16 at 6:45 p.m., the Administrator was made aware of the findings.

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 12/6/16 through 12/8/16. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 1118 certified bed facility was 1113 at the time of the survey. The survey sample consisted of 20 current resident reviews (Residents #1 through #20) and six closed record reviews (Residents #21 through #26).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-140. Policies and procedures Based on staff interview and facility document review, it was determined that the facility staff failed to provide written record of an annual policy and procedure review. The findings include: On 12/6/16 at approximately 11:00 a.m. during the entrance conference, ASM #1 (the executive director) and ASM #2 (the nurse executive) were asked to provide documentation to evidence all facility policies had been annually reviewed for the last two years. On 12/7/16 at 11:05 a.m., an interview was conducted with ASM #2. ASM #2 stated the facility policies were online and updated by the corporation. ASM #2 stated the quality assurance coordinator receives the policies and then the	F 001	1. No residents were affected by the deficient practice. 2. Multiple residents could be affected by this deficient practice. 3. The Center Executive Director (CED) will in-service center-management personnel on the facility policy Facility Policies and Procedures – Annual Reviews. 4. The CED will ensure that all facility policies are annually reviewed, with evidence for review that said reviews have been conducted per regulation and policy.	1/21/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Center Executive Director — (X6) DATE: 12-27-16

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F 001	Continued From Page 1	F 001		

administrative team signs them. ASM #2 stated this process occurs during the monthly quality assurance meetings and is only done for new policies or updated policies. ASM #2 was made aware this surveyor needed to see evidence that all policies had been annually reviewed. ASM #2 stated all policies had been reviewed but this was documented in a different format. ASM #2 was asked to provide documentation to evidence this.

On 12/8/16 at 12:00 p.m., ASM #1 and ASM #2 presented a form that documented,
"(Name of corporation)
Center Operations Policies and Procedures
SIGNATURE PAGE
(Name of facility)
007-2014
(Revision Number)
To adopt this manual and/or revision, it must be reviewed and accepted by your Center's Quality Assurance Committee. The Signature Page must be signed by the following individuals responsible for implementing administrative and clinical policies for the Center which serve as a guide to the care provided."

The form was signed by the nurse executive and the medical director. The form was dated 1/28/16. The section for the administrator's signature and date was blank (Note- the former administrator was no longer employed at the facility and the current administrator had been employed there for three weeks). At this time, ASM #1 stated he had just found this form today after he called the corporate office. This surveyor asked ASM #1 and ASM #2 to clarify if the form had just been signed by the nurse executive and medical director this day since the form was just found this day. ASM #1 and ASM #2 confirmed the form had just been signed this day. ASM #2 was asked why the form was dated 1/28/16 if it had been signed

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F 001	Continued From Page 2	F 001		

this day. ASM #2 stated the facility policies were reviewed on 1/28/16 but she couldn't find the form to evidence this.

The facility policy titled, "Facility Policies and Procedures- Annual Reviews" documented in part, "Our facility reviews its operational policies and procedures and resident care policies as needed and at least annually. Policy Interpretation and Implementation: 1. To ensure that our facility's operational policies and procedures are maintained on a current basis, the quality assurance and assessment committee will review our operational policies and procedures and resident care policies: a. Whenever changes in regulations dictate such revisions; b. Whenever new professional standards of practice require modification of our policies and procedures; c. Whenever new procedures are necessary to ensure that each resident's needs and services are met in accordance with his/her assessment and plan of care; and d. at least annually..."

No further information was presented prior to exit.

12VAC5-371-220. Nursing services
cross reference to F314.

12VAC5-371-250. Resident assessment and care planning
cross reference to F280.

12VAC5-371-360. Clinical records
cross reference to F514.

12VAC-371-250-A.7 cross references to F250

12VAC-371-220-C.1 cross references to F314

12VAC-371-110-B.3 cross references to F225

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F 001	Continued From Page 3 12VAC-371-140-A cross references to F226 Review of five employee records was completed during the survey. Two of the five employees did not have a Virginia State Police background check completed. On 12/8/16 at 8:15 a.m. a request was made to OSM (other staff member) #9, the human resources manager, for background checks for the two employees. OSM #9 stated that these employees were from the rehabilitation department and the background checks were done by the rehabilitation staff and completed at the corporate office. OSM #9 stated she would call the office. On 12/8/16 at 4:08 p.m. ASM (administrative staff member) #1, the executive director stated, "Our corporate people told me they do not have evidence of the Virginia background checks on those two employees. Review of the facility's policy titled, "Abuse Prohibition" documented, "Process. 2. The Facility shall screen potential employees for a history of abuse, neglect, exploitation, or mistreating residents including checking with the appropriate licensing boards and registries. 2.1 The Facility shall not employ individuals who: 2.1.1. Have been found guilty by a court of law of abusing, neglecting, or mistreating others..." No further information was provided prior to exit. 12VAC5-371-140 E. cross reference to F225, F226 12VAC5-371-250. cross reference to F279, F309 12VAC5-371-220. cross reference to F280, F309	F 001	1. No residents were affected by the deficient practice. 2. Multiple residents could be affected by this deficient practice. HR/Benefits Coordinator reviewed all employee records to determine if there was evidence of a completed a negative Virginia State Police background check. No other deficiency was identified. 3. Center Executive Director (CED) will ensure that all employment candidates, irrespective of department, have a Virginia State Police background check completed as part of the hiring/screening process, the results of the check documented in their file, and that any individual with a record of abusing, neglecting or mistreating others will be flagged and not hired. 4. CED/designee will randomly audit personnel files for a period of six months to determine compliance, with corrective actions take as warrants and results of the audits shared at the monthly QA Committee	1/21/17

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F 001	Continued From Page 4 12VAC5-371-180. cross reference to F334 12VAC5-371-340A. cross reference to F364, F371 12VAC5-371-300. cross reference to F425	F 001		

COMMONWEALTH of VIRGINIA

Virginia Department of Fire Programs

Melvin D. Carter
EXECUTIVE DIRECTOR

State Fire Marshal's Office
Northern Region
471 James Madison Hwy Ste.101
Culpeper, VA 22701
Phone: 540/ 317-7670
Fax: 540/ 727-7041

Kathaleen Creegan-Tedeschi, Director
Office of Licensure/Certification
Division of Long Term Care
Virginia Department of Health
9960 Mayland Drive
Perimeter Center Suite 401
Henrico, VA 23233

RE: Woodmont Center
11 Dairy Lane
Fredericksburg, VA 22404
File Number: **N-0326-001**
CMS Certification Number: **495246**
Event ID Number: **UKHU21**

The attached report is forwarded to you with the following comments:

I. SURVEY [X]

[ ] Recommend certification based on compliance with Life Safety Code.
[X] Recommend certification based on acceptable POC.
[ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
[ ] Recommend certification based on compliance with LSC by requested continuous waiver.
[ ] Recommend certification based on compliance with LSC by requested Time Limited waiver.
[ ] Recommend certification based on satisfactory results from application of the FSES.
[ ] Do not recommend certification.

II. POST SURVEY [ ]

[ ] All deficiencies corrected:

[ ] All deficiencies not corrected:

- [ ] Recommend certification based on acceptable POC
- [ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
- [ ] Recommend certification based on approved or requested continuous waiver.
- [ ] Recommend certification based on approved or requested Time Limited waiver.
- [ ] Do not recommend certification.

If you have any questions or if we may be of further assistance, please contact me at 804-371-0220

Sincerely,

Ronald C. Reynolds - JJC

Ronald C. Reynolds
Deputy State Fire Marshal

Survey Date: 12/20/2016 SOD Sent: 12/21/2016 POC Rec ' d: 12/30/2016 POC to HQ: 01/10/2017
Highest Scope/Severity: F

Woodmont Center
Genesis HealthCare

11 Dairy Lane; PO Box 419
Fredericksburg, VA 22405-2663
Tel 540-371-9414
Fax 540-371-4501

December 30, 2016

Virginia Department of Fire Programs
State Fire Marshal's Office – Northern Region
ATTN: Robert Parker
471 James Madison Highwy, Ste 101
Culpeper, VA 22701

Re: Plan of Correction – Life Safety Code Survey

Mr. Parker:

Woodmont Center is in receipt of your notice of deficiencies as a result of the Life Safety Code survey conducted by your office on December 20, 2016. Enclosed is the Plan of Correction without admitting or denying the validity or existence of the alleged deficiencies. This Plan of Correction is prepared and executed solely because it is required by the provisions of the Federal and State law.

We request that you consider this Plan of Correction as this facility's allegation of substantial compliance effective February 2, 2017.

If you have any questions, or further clarification/information, please do not hesitate to contact me at 540/371-9414, Ext 4122, or by e-mail: james.harris@genesishcc.com

Sincerely,

James M. Harris, MA, LNHA
Center Executive Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS An unannounced recertification Life Safety Code Survey was conducted on 12/19/2016 in accordance with 42 code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid.	K 000		
K 271 SS=E	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38 This Standard is not met as evidenced by: Based on observation the facility does not have a all weather surface at exit discharge. This has the possiblity to affect 50% of the residents. The Findings Include: On 12/20/2016 at approximately 10:45 AM hours, it was identified by observation that the facility failed to have a all weather surface at the exit discharge from Cardinal and Dove Hallways.	K 271	1. On 12/21/16, facility Maintenance Director requested a quote from a local, general contractor to install approximately 450 linear feet of sidewalk at rear exits, to provide a hard surface for emergency resident evacuations. 2. The facility Maintenance Dept personnel walked the outside of the building, to address any other exits in need of hard surfaces for emergency evacuation. 3. Risk Assessment documents will be put into place to address any facility exits that do not meet the K-271 regulation. 4. Maintenance Director/designee will monitor and evaluate all Risk Assessment documents to ensure operation meets hard-surface requirements. Results of these RA evaluations will be shared at the monthly QA Committee meetings x3 months.	2/2/17
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing	K 353		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Center Executive Directo	12-30-16

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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K 353	Continued From page 1 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based on observation and records review the facility failed to maintain the sprinkler system. This has the possibility to affect 35% of the residents. The Findings Include: On 12/20/2016 at approximately 9:18 AM hours, it was identified by records review and observation there were the facility failed to maintain 14 sprinkler heads.	K 353	1. On 11/29/16, the facility had their annual sprinkler-system inspection completed by VSC Fire & Security, which identified heads in need of replacement. On 12/6/16, the facility Maintenance Director received a price quote from this contracted vendor to replace these identified heads with heads of non-corrosive material. Work is scheduled to be completed by if not prior to the compliance date. 2. Maintenance Director will ensure that the sprinkler system is inspected on both a quarterly and annual basis by VSC Fire & Security, with any issues addressed and resolved in a timely manner. 3. Along with the aforementioned inspections, the Maintenance Director/designee will monitor (visualize) sprinker heads throughout the facility, with	2/2/17
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		

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WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

(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
K 901	Continued From page 2 This Standard is not met as evidenced by: Based on interview the facility failed to perform a Risk Assessment. This has the possibility to affect 100% of the residents. The Findings Include: On 12/20/2016 at approximately 10:00 AM hours, it was identified by interview the facility failed to perform a Risk Assessment Procedure.	K 901	1. The facility Maintenance Director contacted the Corporate Safety Director, Eastern Region, requesting assistance, guidance and support in creating a Risk Assessment Policy & Procedure for this operation, consistent with K 901 and NFPA 99. 2. On 12/23/16, the facility Maintenance Director reviewed the new Life Safety codes to determine compliance with other policy and documentation requirements consistent with periodic facility inspections. 3. Center Executive Director will ensure the Risk Assessment Policy is implemented, and periodic risk assessments conducted consistent with the requirements under NFPA 99. 4. Results of the risk assessments will be shared and reviewed at the monthly QA Committee meetings as part of the standard meeting agenda.	2/2/17