| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495345 | A. BUILDING _____ B. WING _____ | C 09/15/2016 |

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| LANCASHIRE CONVALESCENT AND REHABILITATION CENTER | 287 SCHOOL STREET KILMARNOCK, VA 22482 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted on 9/13/2016 through 9/15/2016. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey.<br><br>The census in this 120 certified bed facility was 75 at the time of the survey. The survey sample consisted of current Resident reviews (Residents 1-13) and 3 closed record reviews (Residents 14 - 16). | F 000 | | |
| F 157 SS=D | NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br>CFR(s): 483.10(b)(11)<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative | F 157 | | 10/26/16 |

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

Electronically Signed | 10/05/2016

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| F 157 | Continued From page 1<br>or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, family interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure the physician and responsible party were notified of medications not available for administration to 1 resident (Resident #11) of 17 residents in the survey sample.<br><br>For Resident #11, the physician and responsible party were not notified when CHOLESTYRAMINE was not available/not given. Resident #11 missed 5 doses of this prescribed medication. CHOLESTYRAMINE is a medication for the treatment of diarrhea.<br>The findings included:<br><br>Resident #11 was admitted to the facility on 8/22/16. Diagnoses for Resident #11 included but not limited to Type 2 Diabetes, hypertension, chronic kidney disease, and unspecified diarrhea.<br><br>Resident #11's admission Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date (ARD) of 8/29/16 was coded a Brief Interview for Mental Status | F 157 | F157<br>The dates of completion serve as my allegation of compliance.<br>1. The medical record for resident #11 was reviewed for the past 30 days to ensure the physician and responsible party have been notified of any unavailable medications in a timely manner. The nurses responsible for notifying the physician and responsible party of a missed medication administration have been reeducated on the importance of notification of changes.<br>2. The Charge Nurse / Designee will review the medication administration record notes for all residents for the last 30 days to ensure any instances of unavailable medications have been relayed to the physician and responsible parties. If omissions in notifications are found, the attending physician and responsible party will be notified and such notification will be documented in the clinical record. The Medication / Treatment Nurse on each shift will be | |

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| F 157 | Continued From page 2<br>(BIMS) score of 2, severe cognitive impairment. Resident #11 was coded as requiring extensive assistance with his Activities of Daily Living (ADLs) except for eating, in which he was coded as requiring supervision. Resident #11 was coded as being occasionally incontinent of urine and frequently incontinent of bowel. For bathing, Resident #11 was coded as being totally dependent on one staff member for assistance.<br><br>On 9/13/16 at 2:50 p.m., during a tour of the facility, Resident #11 was observed in his wheelchair. His spouse was pushing the wheelchair into Resident #11's room.<br><br>On 9/13/16 at 4:30 p.m., a review of Resident #11's comprehensive careplan included a Problem (Effective 8/23/16-Present) that read, "[Resident's Nick Name] has experienced or is at risk for dehydration due to chronic diarrhea."<br><br>On 9/14/16 at 8:30 a.m., a review of Resident #11's clinical record was conducted. The review revealed the following:<br>1. A physician order 8/22/16, "CHOLESTYRAMINE 4 grams Powder for Diarrhea."<br>2. August and September 2016 Medication Administration Records (MAR), CHOLESTYRAMINE was not available for administration on 8/27, 8/28, 9/3, 9/4 and 9/14. The NON-PRN(as needed) Medication Notes for these dates read, "Not in from Pharmacy."<br>3. Clinical notes and documentation did not reveal an increase in loose stools during the time frame in which the medication was not available for administration.<br>4. CHOLESTYRAMINE was not including on the list of medications in the facility's emergency | F 157 | responsible for notifying the attending physician and responsible party of any unavailable medications.<br>3. RN/LPNs will be reeducated by the Nursing Education and Training Coordinator / Designee on Notification of Change. The in-service will include but is not limited to review of the facility policy on "Medication Shortages and Unavailable Medications" as well as the importance of notifying the attending physicians and responsible parties regarding any change in resident condition or status.<br>4. The Director of Nursing / Designee will audit 20% of Medication Administration Records weekly for six weeks to identify any residents with medications not available. The audit will include a review of the record to ensure the physician and responsible party have been notified in a timely manner. Any trends or patterns will be reported to the Quality Assurance Committee at least quarterly. | |

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| F 157 | Continued From page 3<br>(STAT) box of medications.<br>5. The Clinical Notes Report did not reveal Resident #11's physician or responsible party was notified of the five doses of CHOLESTYRAMINE that were not available for administration.<br><br>On 9/14/16 at 3:30 p.m., Resident #11 was observed in his room in his bed. The head of his bed was elevated and there were three pillows positioned under his head. Resident #11's wife agreed to an interview and shared her concerns for husband's care. During the interview, Resident #11's spouse said, "Yes, he has had a lot of loose stools since he has been here. They (the nursing staff) don't tell me when he has diarrhea. I think it may be from the artificial sweeteners in the sugar-free food they give him."<br><br>On 9/15/16 at 10:00 a.m., an interview was conducted with the Director of Nursing (DON). After reviewing Resident#11's MARs, the DON stated there was no evidence staff had notified the physician or responsible party that Resident #11's CHOLESTYRAMINE was not available for administration. The DON said the expectation was for staff to notify the physician when medications were not available for administration.<br><br>On 9/15/16 at 2:50 p.m., the Administrator, DON and nurse consultant were made aware of these findings. No additional information was provided. | F 157 | | |
| F 176 SS=D | RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br>CFR(s): 483.10(n)<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this | F 176 | | 10/26/16 |

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| F 176 | Continued From page 4<br>practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review the facility staff failed for one resident (Resident #1) of 17 residents in the survey sample to ensure medications were administered in a safe manner.<br><br>1. Resident #1 was observed to self administer medication in the wrong amount. Resident #1 had not been assessed to self administer medications.<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on 8/27/15. Diagnoses included: High blood pressure, allergic rhinitis, chronic pain syndrome and hypothyroidism. The latest MDS (minimum data set) with an ARD (assessment reference date) of 8/10/16 coded the resident with a BIMS (brief interview of mental status) score of "15" out of a possible 15, or no cognitive impairment.<br><br>On 9/14/16, at approximately 8:35 AM, Resident #1's medication pass was observed. The pills were poured and given whole with water. LPN (A) gave Resident #1 her Flonase bottle. Resident #1 proceeded to give herself two sprays of the Flonase for each nostril. LPN (A) did not instruct the resident to administer one spray to each nostril.<br><br>Review of the physician's orders dated 8/25/16 revealed the physician's order for Flonase 50 mcg (micrograms)/ actuation (one spray) was for | F 176 | F176<br>The dates of completion serve as my allegation of compliance.<br>1. Resident #1 was assessed for safety in self-administration of Flonase Nasal Spray. Her care plan was updated to reflect her competence, and ability to self-administer her Flonase Nasal Spray as ordered and the order was reviewed with her. The nurse responsible for allowing resident to self-administer Flonase Nasal Spray has been reeducated on giving instructions and reviewing order with resident prior to self-administration of medications.<br>2. The Director of Nursing / Designee will assess all residents who wish to self-administer medications to ensure the resident is safe to perform task. Those residents will be reviewed and assessed by the Interdisciplinary Team (IDT) and their care plan updated as indicated. The Medication Nurse will ensure residents□ medications are administered according to physician□s order, with appropriate instructions given to residents, and ensure the Director of Nursing and IDT are notified of any resident requesting to self-administer medications so appropriate assessment can be completed.<br>3. RN/LPNS and IDT will be reeducated by the Nursing Education and Training Coordinator / Designee on | |

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| F 176 | Continued From page 5<br>one spray each nostril.<br><br>On 9/14/16 at approximately 11:00 AM, the DON was asked if Resident #1 had been assessed for self administration of medications. The DON stated, "She has no self administration assessment."<br><br>On 9/14/16 at 11:15 AM, the Administrator and DON were notified of the concern. | F 176 | Self-Administration of Medications. The in-service will include but is not limited to review of the facility policy and medication administration guidelines on self-administration of medications.<br>4. The Director of Nursing / Designee will interview / review 10 residents weekly for six weeks to identify residents wishing to self-administer medications. An assessment will be completed and care plan updated as indicated. Any trends or patterns will be reported to the Quality Assurance Committee at least quarterly. | |
| F 278 SS=D | ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br>CFR(s): 483.20(g) - (j)<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a | F 278 | | 10/26/16 |

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| F 278 | Continued From page 6<br>resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to complete an accurate MDS (minimum data set) RAI (Resident Assessment Instrument) for one Resident (Resident #2) in a survey sample of 17 Residents.<br><br>For Resident #2, the facility staff failed to document the location, date and source of information (supporting documentation) used to complete the CAA (Care Area Assessment) worksheets.<br><br>Guidance within the "Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.13, October 2015, page 4-7, :<br><br>"Written documentation of the CAA findings and decision making process may appear anywhere in a resident's record; for example, in discipline specific flow sheets, the care plan summary notes, progress notes, a CAA summary narrative, etc. Nursing homes should use a format that provides the information as outlined in this manual and in the State Operations Manual (SOM).<br><br>Use the "Location and Date of CAA Documentation" column on the CAA summary | F 278 | F278<br>The dates of completion serve as my allegation of compliance.<br>1. Resident #2□s CAA worksheet of the MDS with an ARD of 8/16/16 was updated to include location, date, and source for the following items: triggered Diseases and Conditions; triggered Internal Risk Factors; triggered Fall Indicators; and triggered Urinary Incontinence and Modifiable Factors.<br>2. The Resident Assessment Coordinator/ Designee will audit the comprehensive MDSs for current residents completed in the last 30 days to ensure complete documentation is presented on the CAA worksheet. Any discrepancies will be noted and corrected. The Resident Assessment Coordinator will be responsible for ensuring the CAA worksheet includes location, date, and source for triggers.<br>3. Facility MDS team will be reeducated by the Corporate Resident Assessment Coordinator/ Designee. The in-service will include but is not limited to review of the Resident Assessment Instrument (RAI) guidelines for documenting CAA findings.<br>4. The Assistant Director of Nursing / | |

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| F 278 | Continued From page 7<br>(Section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's record..."<br><br>The findings included:<br><br>Resident #2 was admitted to the facility 4/6/16 and readmitted after hospitalization on 8/11/2016. Her diagnoses included anemia, coronary artery disease, hypertension, renal insufficiency, neurogenic bladder, diabetes, Alzheimer's disease, paraplegia, depression, and glaucoma.<br><br>Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/16/16 was coded as a significant change assessment. Resident #2 was coded a BIMS (brief interview of mental status) score of 12, moderate cognitive impairment. Resident #2 was coded as requiring extensive to total assistance of one to two staff members to perform her activities of daily living (ADLs).<br><br>Review of this comprehensive assessment revealed in Section V- CAA Summary, a notation by each triggered area referring the reader to a CAA worksheet for the "Location and Date" of where the information used to complete the CAA was located. Review of the CAA worksheets for some of the triggered areas did not include where the information was provided and did not include the date of the information. The following supporting documentation was not provided in the CAA worksheets:<br>1. location, date and source for triggered Diseases and Conditions.<br>2. location, date and source for triggered Internal Risk Factors. | F 278 | Designee will review 20% of comprehensive MDSs completed weekly for six weeks to ensure accuracy of CAA worksheets. Any trends or patterns will be reported to the Quality Assurance Committee at least quarterly. | |

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| F 278 | Continued From page 8<br>3. location, date and source for triggered Fall Indicators<br>4. location, date and source for triggered Urinary Incontinence and Modifiable factors.<br>The MDS was signed by the ADON (Assistant Director of Nursing), Emp (Employee) C.<br><br>On 4/15/16 at 10:45 a.m., an interview was conducted with Emp C regarding the completion of CAA worksheets. After reviewing Resident #2's MDS, Emp C stated, "I just have to go into more detail."<br><br>On 9/15/16 at 2:50 p.m., the administrator, director of nursing, and the corporate consultant were informed of the failure of the staff to include the location, date and source of the information used to complete Resident #2's comprehensive assessment. No additional information was provided. | F 278 | | |
| F 280 SS=D | RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br>CFR(s): 483.20(d)(3), 483.10(k)(2)<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of | F 280 | | 10/26/16 |

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| F 280 | Continued From page 9<br>the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, family interview, staff interview, and clinical record review, the facility staff failed to review and revise the comprehensive plan of care for one Resident (Resident #11) in a survey sample of 17 Residents.<br><br>For Resident #11, functional support and interventions for his Activities of Daily (ADL) were not included in his comprehensive careplan.<br><br>The findings included:<br><br>Resident #11 was admitted to the facility on 8/22/16. Diagnoses for Resident #11 included but not limited to Type 2 Diabetes, hypertension, chronic kidney disease, and unspecified diarrhea.<br><br>Resident #11's admission Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date (ARD) of 8/29/16 was coded a Brief Interview for Mental Status (BIMS) score of 2, severe cognitive impairment. Resident #11 was coded as requiring extensive assistance with his Activities of Daily Living (ADLS) except for eating, in which he was coded as requiring supervision. Resident #11 was coded as being occasionally incontinent of urine and frequently incontinent of bowel. | F 280 | F280<br>The dates of completion serve as my allegation of compliance.<br>1. The care plan for Resident #11 was reviewed and revised to include interventions for his functional deficits and ADL support needs. The Assistant Director of Nursing / Designee was reeducated on ensuring resident care plans are updated as needed and are reflective of individual needs and conditions.<br>2. The Assistant Director of Nursing / Designee will review all resident care plans to ensure that residents current ADL function and support needs are documented and updated. The Assistant Director of Nursing / Designee will be responsible for ensuring that resident care plans are updated as indicated based on individual needs and conditions.<br>3. RN/LPNs will be reeducated by the Nursing Education and Training Coordinator / Designee on Comprehensive Resident Care Plans. The in-service will include but is not limited to review of facility policy on care plans and the importance of ensuring that care plans are developed based on the resident | |

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| F 280 | Continued From page 10<br><br>Resident #11 was observed on numerous occasions during the survey period. On 9/13/16 at 2:50 p.m., during a tour of the facility, Resident #11 was observed in his wheelchair. His spouse was pushing the wheelchair into Resident #11's room. On 9/14/16 at 3:30 p.m., Resident #11 was observed being assisted by a CNA (certified nursing assistant) to his room and transferred to his bed. The head of his bed was elevated and there were three pillows positioned under his head. On 9/15/16 at 12:30 p.m., Resident #11 was in the activity/dining area with his spouse and his spouse was observed feeding him his lunch.<br><br>On 9/13/16 at 4:30 p.m., Resident #11's comprehensive careplan was reviewed and did not reveal interventions for his functional deficits and ADL support needs. A somewhat related ADL care plan read, "Direct care staff believe Resident is capable of increased independence in at least some ADLS. " The Interventions read, "Allow Resident to complete as much of the task as possible. Assist as needed." According the current comprehensive assessment which was based on the staff ADL documentation during the ARD period, Resident #11's ADL support needs were extensive. The following functional specifics and support needs coded in the MDS were not addressed in Resident #11's comprehensive care plan:<br>1. Bed Mobility and Transfer - number of staff needed to assist.<br>2. Dressing, Personal Hygiene- coded as requiring extensive assistance.<br><br>A review of the nursing admission note, dated 8/23/16 specifically read, "Resident is a feeder." This functional need was not identified in | F 280 | assessment and updated as necessary to reflect current needs and conditions. The in-service will also include a review of the importance of timely revision of care plans to ensure they accurately address residents□ needs and current statuses.<br>4. The Director of Nursing / Designee will audit 10% weekly for six weeks of all resident care plans to ensure that care plans reflect the current ADL function and support and are updated with any changes in a timely manner. Any trends or patterns will be reported to the Quality Assurance Committee at least quarterly. | |

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Resident #11's care plan.

On 9/14/16 at 11:00 a.m., an interview was conducted with the ADON (Assistant Director of Nursing), Employee (Emp) C regarding Resident #11's careplan and the lack of specific interventions to address functional deficits and ADL support needs. After reviewing Resident #11's comprehensive care plan, Emp C said she did not create the careplan and that some of the Resident's care needs were scattered throughout the careplan.

On 9/14/16 at 3:35 p.m., Resident #11's spouse was interviewed. From 3:35 p.m. - 4:15 p.m., Resident #11's wife spoke at length regarding her concerns for her husband's care. During the interview, Resident #11's spouse said, "He has to have his head elevated or he will pass out. I think I finally got the staff to understand how important it is for him to keep his head elevated when he is in bed. He just can't lay flat." Resident #11's spouse also spoke about her husband's toileting needs and assistance with eating and bathing. She added, "And I know he went at least a week without having a shower. They (the nursing staff) won't even tell me what days he is suppose to get a shower."

On 9/15/16 at 11:35 a.m., an interview was conducted with the DON (Director of Nursing) regarding Resident #11's need to have his head elevated on pillows to prevent him from passing out. The DON said she wasn't aware of this need and that she would check into it. The DON returned with a Psychiatry Consultation Note, dated 8/30/16, that read, "The patient's cognitive issues may be due to vascular origin as wife gives a strong history of carotid occlusion after

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which the patient has lost consciousness every time he has turned his neck and has been taken to the Emergency Room more than 3 times for the same reason ..." The DON (Director of Nursing) said she would check with Resident #11's physician and care plan any concerns accordingly.

Guidance for the creation of an individualized care plan was provided by "Fundamentals of Nursing 7th Edition, Potter-Perry, page. 268:

In any health care setting a nurse is responsible for providing a written pan of care for all clients. The plan of care sometimes takes several forms...In hospitals and community-based settings, the client often receives care from more than one nurse, physician, or allied health professional. A written nursing care plan makes possible the coordination of nursing care, subspecialty consultations, and scheduling of diagnostic tests...You design a written plan to direct clinical nursing care and to decrease the risk of incomplete, incorrect, or inaccurate care. As the client's problems and status change, so does the plan. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used in evaluation. The written plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of nursing care by listing specific nursing interventions needed to achieve the goals of care. All nurses who care for a given client will then carry out these nursing interventions throughout a given day during a client's length of stay. A correctly formulated nursing care plan makes it easier to continue care from one nurse to another."

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| F 280 | Continued From page 13<br><br>On 9/15/16 at 2:50 p.m., the administrator, DON and corporate consultant were informed of the failure of the staff to ensure Resident #11's comprehensive careplan included interventions for his functional deficits and support needs. No additional information was provided. | F 280 | | |
| F 281 SS=D | SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br>CFR(s): 483.20(k)(3)(i)<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of nursing for medication administration for one Resident (Resident #4) in a survey sample of 17 Residents.<br><br>For Resident #4, the facility staff failed to ensure medications were documented as having been administered for the following dates:<br><br>1. Artificial Tears .5-.6% for Dry Eye Syndrome - 2:00 p.m. on 8/6, 8/7, and 8/19. 8:00 p.m. on 9/5.<br>2. Trazodone 80 mg (milligram) for Insomnia - 9/5.<br>3. Percocet 5-325 mg for Pain - 9/5.<br><br>The findings included: | F 281 | F281<br>The dates of completion serve as my allegation of compliance.<br>1. Resident #4 was assessed and was without negative outcome related to medications not being documented as administered. The nurses responsible for administering medications to resident have been reeducated on the importance of documentation of medication administration.<br>2. The Director of Nursing / Designee will review medication records of current residents for the past 30 days to ensure medications have been administered as ordered with appropriate documentation. The Medication Nurse on each shift will be responsible for ensuring medications have been documented as administered in accordance with professional standards of nursing. | 10/26/16 |

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| F 281 | Continued From page 14<br><br>Resident #4 was initially admitted to the facility on 6/1/16 and readmitted after hospitalization on 9/5/16. Diagnoses included hypertension, quadriplegia, insomnia, peripheral vascular disease, pressure ulcers to the right heel and sacral region, and chronic dry eye syndrome.<br><br>Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/10/16 was coded as an admission assessment. Resident #4 was coded a BIMS (Brief Interview of Mental Status) score of 12, moderately impaired cognition. Resident #4 was coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living.<br><br>On 9/14/16 at 8:45 a.m., a review of Resident #4's clinical record was conducted. Review of Resident #4's August and September 2016 MAR (Medication Administration Record) revealed "=" symbol instead of a nurse's initial for the following medication administrations:<br>1. Artificial Tears .5-.6% for Dry Eye Syndrome - 2:00 p.m. on 8/6, 8/7, and 8/19. 8:00 p.m. on 9/5.<br>2. Trazodone 80 mg (milligram) for Insomnia - 9/5.<br>3. Percocet 5-325 mg for Pain - 9/5.<br><br>According to the legend located on each page of the MAR, the "=" sign meant 'Previously Scheduled'.<br><br>On 9/15/16 at 10:30 a.m., the DON (Director of Nursing) was shown Resident #4's MARs with the equal sign in the area designated for a nurse's initial. The DON explained that the equal sign meant the nurse did not document anything. The | F 281 | 3. RN/LPNs will be reeducated by the Nursing Education and Training Coordinator on Medication Administration and Documentation. The in-service will include but is not limited to review of the Medication Administration Guidelines policy as well as professional standards for administration of medications to include documentation.<br>4. The Director of Nursing / Designee will audit 20% of medication administration records weekly for six weeks to ensure medications have been administered and documented as ordered. Any trends or patterns will be reported to the Quality Assurance Committee at least quarterly. | |

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DON stated, "If the nurse didn't document the medication was administered within a certain time frame, an equal sign would automatically be placed the box." The DON said the expectation was for the nurses to document with their initial after administering a medication.

On 9/15/16 at 11:50 a.m., LPN (licensed practical nurse) B was shown Resident #4's MAR with the '=" sign and she was asked what the "=" sign meant. LPN B said, "I don't know what that means or how to even put that on the MAR."

On 9/15/16 at 2:15 p.m., a follow-up interview was conducted with the DON regarding the "=" symbol. The DON said there was no way of knowing if the medication had been administered when there was an equal sign in the block where the nurse should have initialed. For clarification, the DON said the "=" sign was the same as a blank.

A thorough review of Resident #4's clinical record revealed no evidence the medications in question had been administered or refused. There was no evidence that Resident #4 was not in the facility at the time the medications were scheduled for administration. Valid physician's orders were evident for the medications in question.

Review of the facility's policy entitled, " Medications-Oral Administration" included:

"The resident's MAR/TAR (treatment administration record) is initialed by the person administering a medication, in the space provided under the date, and on the line for that specific medication dose administration."

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| F 281 | Continued From page 16<br>On 9/15/16 at 2:20 p.m., during an end of day briefing, Potter and Perry's , 'Fundamentals of Nursing' was cited by the corporate nurse consultant, Emp D, as one of the facility's references for professional standards of nursing.<br><br>Guidance regarding medication documentation was given to nursing by "Fundamentals of Nursing 7th Edition, Potter-Perry, page 713, "After administering a medication, record it immediately on the appropriate record form."<br><br>On 9/15/16 at 2:50 p.m., the administrator, DON and corporate nurse consultant were informed of the failure of the staff to ensure medications were documented as having been administered per nursing standards for Resident #4. No additional information was provided. | F 281 | | |
| F 332 SS=D | FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br>CFR(s): 483.25(m)(1)<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medication pass observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure a medication error rate of less than 5%.<br><br>The facility's medication error rate was 7 %. There were two errors in 26 opportunities.<br><br>1. Resident #8's pills were not crushed and | F 332 | F332<br>The dates of completion serve as my allegation of compliance.<br>1. Residents #1 and #8 were assessed and found to be without negative outcome related to the medication error. The nurses involved in medication administration errors were reeducated on the Medication Administration guidelines | 10/26/16 |

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| F 332 | Continued From page 17<br>administered separately with 20 cc (cubic centimeters) of water between each medication.<br><br>2. Resident #1 administered two sprays of her Flonase instead of one spray each nostril as the physician ordered.<br><br>The findings included:<br><br>1. Resident #8 was admitted on 7/26/16. Diagnoses included high blood pressure, diabetes and aphasia. The resident had a gastrostomy tube (tube inserted into the stomach through the abdomen for food, fluids and medications).<br><br>On 9/13/16, the medication pass was observed. At approximately 4:15 PM, LPN (licensed practical nurse-C) poured three pills- a multivitamin, Labetolol (blood pressure medication), and Vitamin D. These pills were crushed together and administered to Resident #8 via the gastrostomy tube in one administration.<br><br>Review of the facility policy on "Feeding Tube-Medication Administration" revealed the following: "All medications are to be given separately with at least 5 cc (cubic centimeters) of water to flush, unless otherwise ordered by the physician."<br><br>On 9/14/16 at approximately 11:00 AM, the DON (director of nursing) stated, "The medications should be given separately."<br><br>2. Resident #1 was admitted to the facility on 8/27/15. Diagnoses included: High blood pressure, allergic rhinitis, chronic pain syndrome and hypothyroidism. The latest MDS (minimum data set) with an ARD (assessment reference | F 332 | regarding administration of medications via gastrostomy tube and following physician residents orders regarding nasal spray.<br>2. The Director of Nursing / Designee will observe RNs and LPNs administering medications via gastrostomy tubes and nasal sprays to ensure residents are free from medication errors. The Medication Nurse on each shift will be responsible for ensuring medication passes are completed in accordance with professional standards of nursing.<br>3. RN/LPNs will be reeducated by the Nursing Education and Training Coordinator / Designee on Medication Administration. The in-service will include but is not limited to review of guidelines for administering medications via various routes, such as enteral tubes, and the Rights of Medication Administration.<br>4. Nursing Education and Training Coordinator/Designee will complete five medication pass audits weekly for six weeks utilizing the Medication Pass Observation Audit and forward the results to the Director of Nursing. Any trends or patterns will be reported to the Quality Assurance Committee at least quarterly. | |

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| F 332 | Continued From page 18<br>date) of 8/10/16 coded the resident with a BIMS (brief interview of mental status) score of "15" out of a possible 15, or no cognitive impairment.<br><br>On 9/14/16, at approximately 8:35 AM, Resident #1's medication pass was observed. The pills were poured and given whole with water. LPN (A) gave Resident #1 her Flonase bottle. Resident #1 proceeded to give herself two sprays of the Flonase for each nostril.<br><br>Review of the physician's orders dated 8/25/16 revealed the physician's order for Flonase 50 mcg (micrograms)/ actuation (one spray) one spray each nostril.<br><br>On 9/14/16 at approximately 11:00 AM, the DON was asked if Resident #1 had been assessed for self administration of medications. The DON stated, "She has no self administration assessment."<br><br>On 9/14/16 at 11:15 AM, the Administrator and DON were notified of the error. | F 332 | | |
| F 425 SS=D | PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br>CFR(s): 483.60(a),(b)<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services | F 425 | | 10/26/16 |

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| F 425 | Continued From page 19<br>(including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review and clinical record review, the facility staff failed to ensure a physician ordered medication was available for administration for one Resident (Resident #11) of 17 residents in the survey sample.<br><br>For Resident #11, CHOLESTYRAMINE was not available for administration on five occasions. Cholestyramine is a medication for the treatment of diarrhea.<br><br>The findings included:<br><br>Resident #11 was admitted to the facility on 8/22/16. Diagnoses for Resident #11 included but not limited to Type 2 Diabetes, hypertension, chronic kidney disease, and unspecified diarrhea.<br><br>Resident #11's admission Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date (ARD) of 8/29/16 was coded a Brief Interview for Mental Status (BIMS) score of 2, severe cognitive impairment. | F 425 | F425<br>The dates of completion serve as my allegation of compliance.<br>1. The medications for Resident #11 were inventoried to ensure all medications were available for administration as ordered. The pharmacy was notified of any medications not available and facility obtained and administered medications as ordered. Resident #11 was assessed and was without negative outcomes related to unavailability of medication. The nurses responsible for administering medications were reeducated on the importance of obtaining medication timely to ensure medication is administered as ordered.<br>2. The Director of Nursing / Designee will review medication records of current residents for the last 30 days to ensure medications are available and administered as ordered . The Medication Nurse on each shift will be responsible for ensuring medications are available for | |

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Resident #11 was coded as requiring extensive assistance with his Activities of Daily Living (ADLs) except for eating, in which he was coded as requiring supervision. Resident #11 was coded as being occasionally incontinent of urine and frequently incontinent of bowel.

On 9/13/16 at 4:30 p.m., a review of Resident #11's comprehensive careplan included a Problem (Effective 8/23/16-Present) that read, "[Resident's Nick Name] has experienced or is at risk for dehydration due to chronic diarrhea."

On 9/14/16 at 8:30 a.m., a review of Resident #11's clinical record was conducted. The review revealed the following:
1. A current physician order dated 8/22/16, "CHOLESTYRAMINE 4 grams Powder for Diarrhea."
2. August and September 2016 Medication Administration Records (MARs), CHOLESTYRAMINE was not available for administration on 8/27, 8/28, 9/3, 9/4 and 9/14. The NON-PRN(as needed) Medication Notes for these dates read, "Not in from Pharmacy."

On 9/15/16 at 10:00 a.m., an interview was conducted with the Director of Nursing (DON). After reviewing Resident #11's MARs, the DON stated the expectation was for staff to contact the pharmacy to make sure the medication was refilled and available for administration. The DON provided a copy of a list of the facility's emergency (STAT) box of medications. CHOLESTYRAMINE was not included on the list.

On 9/15/16 at 11:50 a.m., LPN (Licensed Practical Nurse) B was interviewed regarding Resident #11's CHOLESTYRAMINE which was

administration as ordered and will notify responsible party and physician regarding any variances.
3. RN/LPNs will be reeducated by the Nursing Education and Training Coordinator / Designee on Medication Administration and Documentation. The in-service will include but is not limited to a review of "Medication Shortages and Unavailable Medications" policy as well as the importance of obtaining medications from pharmacy timely.
4. The Director of Nursing / Designee will audit 20% of medication administration records weekly for six weeks to ensure that medications are available for administration .Any variances or discrepancies will be corrected immediately. Any trends or patterns will be reported to the Quality Assurance Committee at least quarterly.

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| (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 |
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| F 425 | Continued From page 21<br>documented as being unavailable for administration on the prior day, 9/14/16. LPN B opened the medication cart and pulled out a plastic bag of individually packaged CHOLESTYRAMINE packets. LPN B said, "We have it for him now."<br><br>On 9/15/16 at 2:50 p.m., the Administrator and Director of Nursing were made aware of these findings. No additional information was provided. | F 425 | | |
| F 514 SS=D | RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>CFR(s): 483.75(l)(1)<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for one Resident (Resident #4) in a survey sample of 17 Residents.<br><br>Resident #4's Medication Administration Record | F 514 | F514 □<br>The dates of completion serves as my allegation of compliance.<br>1. The medical record for Resident #4 was reviewed for past 30 days to ensure documentation of nurses□ initials were present on the Medication Administration | 10/26/16 |

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| | 495345 | A. BUILDING _____ B. WING _____ | C 09/15/2016 |

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| F 514 | Continued From page 22<br>(MAR) contained an equal sign (=) in areas designated for the nurse to initial medication administration.<br><br>The findings included:<br><br>Resident #4, was initially admitted to the facility on 6/1/16 and readmitted after hospitalization on 9/5/16. Diagnoses included hypertension, quadriplegia, insomnia, peripheral vascular disease, pressure ulcers to the right heel and sacral region, and chronic dry eye syndrome.<br><br>Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/10/16 was an admission assessment. Resident #4 was coded a BIMS (Brief Interview of Mental Status) score of 12, moderately impaired cognition. Resident #4 was coded as needing extensive to total assistance of one to two staff members to perform activities of daily living (ADLs).<br><br>On 9/14/16 at 8:45 a.m., a review of Resident #4's clinical record was conducted. Review of Resident #4's August and September 2016 MAR (Medication Administration Record) revealed an "=" (equal) symbol instead of a nurse's initial for the following medication administrations:<br>1. Artificial Tears .5-.6% for Dry Eye Syndrome - 2:00 p.m. on 8/6, 8/7, and 8/19. 8:00 p.m. on 9/5.<br>2. Trazodone 80 mg (milligram) for Insomnia - 9/5.<br>3. Percocet 5-325 mg for Pain - 9/5.<br><br>According to the legend located on each page of the MAR, the "=" sign meant 'Previously Scheduled'. | F 514 | Record (MAR) indicating medication was administered as ordered. The nurses responsible for administering and documenting administration of medications for Resident #4 have been reeducated on the importance of accurate and complete documentation of medication administration.<br>2. The Director of Nursing / Designee will review the medication records of current residents for past 30 days to ensure the medical record is accurate and complete. The Medication Nurse on each shift will be responsible for accurately and completely documenting the medication administration in the medical record.<br>3. RN/LPNs will be reeducated by the Nursing Education and Training Coordinator / Designee on Medication Administration and Documentation. The in-service will include but is not limited to review of facility policy on Medication Administration Guidelines as well as professional standards for accurately and completely documenting medication administration in the medical record to ensure the medical record accurately reflects residents□ current status.<br>4. The Director of Nursing / Designee will audit 20% of medication administration records weekly for six weeks to ensure the medical record is accurate and complete . Any trends or patterns will be reported to the Quality Assurance Committee at least quarterly. | |

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| F 514 | Continued From page 23 | F 514 | | |

On 9/15/16 at 10:30 a.m., the DON (Director of Nursing) was shown Resident #4's MARs with the equal sign instead of a nurse's initial. The DON explained that the equal sign meant the nurse did not document anything. The DON stated, "If the nurse doesn't document the medication was administered within a certain time frame, an equal sign with automatically fill the box." The DON said the expectation was for the nurses to document with their initial after administering a medication.

On 9/15/16 at 11:50 a.m., LPN (licensed practical nurse) B was shown Resident #4's MAR with the "=" sign and she was asked what the "=" sign meant. LPN B said, "I don't know what that means or how to even put that on the MAR."

On 9/15/16 at 2:15 p.m., a follow-up interview was conducted with the DON regarding the "=" symbol. The DON said there was no way of knowing if the medication had been administered when there was an equal sign in the block where the nurse should have initialed. For clarification, the DON said the "=" sign was the same as a blank.

A thorough review of Resident #4's clinical record revealed no evidence the medications in question had been administered or refused. There was no evidence that Resident #4 was not in the facility at the time the medications were scheduled for administration. Valid physician's orders were evident for the medications in question.

Review of the facility's policy entitled, " Medications-Oral Administration" included:

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| F 514 | Continued From page 24 | F 514 | | |

"The resident's MAR/TAR (treatment administration record) is initialed by the person administering a medication, in the space provided under the date, and on the line for that specific medication dose administration."

On 9/15/16 at 2:20 p.m., during an end of day briefing, Potter and Perry's , 'Fundamentals of Nursing' was cited by the corporate nurse, Employee D, as one of the facility's references for professional standards of nursing.

Guidance regarding medication documentation was given to nursing by "Fundamentals of Nursing 7th Edition, Potter-Perry, p. 713, "After administering a medication, record it immediately on the appropriate record form."

On 9/15/16 at 2:50 p.m., the administrator, DON and corporate consultant were informed of the failure of the staff to ensure Resident #4's clinical record was complete and accurate. Resident #4's medications were not documented as having been administered per nursing standards. No additional information was provided.