STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM; FOR SNFs AND NFs	PROVIDER # 495139	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 7/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 287	483.20(f)(1)-(4) ENCODING/TRANSMITTING RESIDENT ASSESSMENT

(f) Automated Data Processing Requirement

(1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:

(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

(2) Transmitting Data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:

(i) Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

(4) Data Format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to complete a death in facility MDS (minimum data set) assessment for one of five closed record reviews in the survey sample, Resident #19.

Resident #19 expired in the facility on 5/8/17. The facility staff failed to complete a death in facility MDS assessment.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495139	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 7/20/2017

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The findings include:

Resident #19 was admitted to the facility on 8/29/14. Resident #19's diagnoses included but were not limited to: anxiety disorder, pain and history of falling. Resident #19 expired in the facility on 5/8/17. Review of Resident #19's MDS assessments failed to reveal a death in facility MDS assessment.

On 7/19/17 at 4:18 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (MDS coordinator). LPN #1 was asked if a MDS should be completed when a resident expires. LPN #1 stated, "A death in facility record." LPN #1 was asked what documentation she references when completing MDS assessments. LPN #1 stated she references the RAI (resident assessment instrument) manual. LPN #1 was asked to provide Resident #19's death in facility MDS.

On 7/19/17 at 5:20 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings.

On 7/20/17 at 8:05 a.m. ASM #2 presented Resident #19's death in facility MDS.

On 7/20/17 at 8:28 a.m. another interview was conducted with LPN #1. LPN #1 confirmed she completed Resident #19's death in facility MDS during the previous day. LPN #1 was asked when the assessment should have been completed. LPN #1 stated it should have been completed on 5/8/17. When asked why it wasn't completed on 5/8/17, LPN #1 stated, "Human error."

The CMS (Centers for Medicare and Medicaid Services) RAI manual documented, "08. Death in Facility Tracking Record...Must be completed when the resident dies in the facility or when on LOA (leave of absence). Must be completed within 7 days after the resident's death..."

No further information was presented prior to exit.

F-287
1. How will the corrective action be accomplished for those residents found to have been affected by this deficient practice?
Resident #19 expired in the facility on 5-8-17. Resident's assessment (death) was completed on 7-19-17 and was transmitted on 7-24-17 by LPN (MDS) nurse.
2. How will the facility identify other residents having the potential to be affected by the same deficient practice?
Review of assessment for death in the facility was completed for the last 6 months on 8-1-17 by LPN. One other resident was identified 15023 assessment was completed on 8-17-17 by LPN (MDS) nurse. Assessment was transmitted on 8-1-17 by LPN (MDS) nurse.
3. What measures will be put in place or systemic changes made to ensure the deficient practice will not reoccur.
DON completed Education on 8-2-17 with LPN (MDS) nurses on completion of assessment of death in facility within 7 days. Transmission of electronic assessment within 14 days. Residents will be discussed in grand rounds (am Clinical meeting) every morning by the interdisciplinary team. Residents identified as expiring in facility will be communicated to MDS. MDS assessment for death will be completed within 7 days and transmitted. Audits will be conducted by DON or Unit managers 5 days a week for 30 days then 3 days a week for 30 days then 1 day a week for 30 days to assure MDS is completed and transmitted.
4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur.
DON will present findings of audits for assessments for death in the facility to the Quality assurance/ Performance improvement Committee for 90 days for review and recommendations. The committee consist of the following persons Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary, Director of Rehabilitation, Medical Director, and Pharmacy Consultant.

Executive Director 8/4/17

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F 000	INITIAL COMMENTS	F 000	RECEIVED AUG 07 2017 VDH/OLC	

An unannounced Medicare/Medicaid standard survey was conducted 7/18/17 through 7/20/17. Complaints were investigated during this survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow.

The census in this 118 certified bed facility was 101 at the time of the survey. The survey sample consisted of 23 current resident reviews (Residents #1 through #18, and #25 through #29) and six closed record reviews (Residents #19 through #24).

F 157 SS=E	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157	

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to

Tag F-157.

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

On 8-1-17 Director of Nursing reviewed with In house physician resident's # 11 weights for the month of July 2017. Notification was documented on 8-1-17 in nurse's notes by the Director of Nursing. No new orders were received. Will continue to obtain weight per orders and notify MD per orders and change in condition policy.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 8/4/17

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 157	Continued From page 1	F 157		

commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
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 notify the physician of a change in resident condition for four of 29 residents in the survey sample, Residents #11, #3, #8, and #1.

1. The facility staff failed to notify the physician of a weight gain of more than two pounds in one day multiple times in June 2017 for Resident #11.

On 8-1-17 Director of Nursing reviewed with Medical Director resident # 3 weight loss and the weights for the month of July 2017. Physician was also notified of resident's refusal of weights. Director of Nurse's documented in the nurse's notes physician's notification. No new orders received from physician. Nursing will continue to obtain weights as ordered and notify physician as per order and policy for change in resident's condition.

Resident #8 discharged from facility

On 8-1-17 Director of Nursing reviewed resident #1 weights for the month of July with 2# weight change. No new orders were received. Director of Nurse's documented notification to physician in nurse's notes. Nursing will continue to obtain weight as per physicians orders and notify physician per orders and change of condition policy.

2. How will the facility identify other residents having the potential to be affected by the same practice?

Unit managers reviewed on 8-1-17 all residents with physician orders for weights daily and weekly with orders

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2. The facility staff failed to notify the physician of weight loss of more than four pounds in one week, and of a refusal to be weighed in June 2017 for Resident #3.

3. The facility staff failed to notify the physician/nurse practitioner when oxygen was initiated for Resident #8.

4. The facility staff failed to notify the physician, per the physician orders, of a weight gain of over two pounds in a day for Resident #1.

The findings include:

1. The facility staff failed to notify the physician of a weight gain of more than two pounds in one day multiple times in June 2017 for Resident #11.

Resident #11 was admitted to the facility on 3/25/15 and most recently readmitted on 5/1/17 with diagnoses including, but not limited to: heart failure, high blood pressure, diabetes, and amputation of his left leg below the knee. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 5/8/17, Resident #11 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).

A review of the physician's orders for Resident #11 revealed, in part, the following order dated 5/1/17, and most recently signed by the physician on 7/3/17: "Daily weight. If gains 2 lbs (pounds) or more in a day notify MD/NP (medical doctor/nurse practitioner). Provide copy of weights to MD/NP weekly on Wednesday."

2. How will the facility identify other residents having the potential to be affected by the same practice?

Unit managers reviewed on 8-1-17 all residents with physician orders for weights daily and weekly with orders to notify physician are reviewed for physician notification.

On 8-1-17 Director of nursing reviewed all residents with orders for daily and weekly weights with physician. Director of Nurse's on 8-1-17 documented in nurse's notes physician notification. New orders received were written by Director of Nursing on 8-2-17. Residents weights will be obtained as ordered and notification to physician will be documented on back of treatment administration record.

On 8-1-17 Director of nursing reviewed all residents on O2 for implementation of O2 per standing orders. No other residents were identified.

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A review of the daily weights for Resident #11 revealed, in part, the following:
6/2/17 - 235.9; 6/3/17 - 240.7
6/8/17 - 232.9; 6/9/17 - 235
6/11/17 - 233.8; 6/12/17 - 237.7
6/25/17 - 237.4; 6/26/17 - 242.3
6/28/17 - 243.1; 6/29/17 - 245.8

Further review of Resident #11's clinical record, including the back of the TARs (treatment administration records) and nurses' notes, failed to reveal evidence that the facility staff notified the physician or NP of the weight gains on the above referenced dates.

A review of the comprehensive care plan for Resident #11 dated 7/27/16 and updated 11/17/16 revealed, in part, the following: "Daily weights...prior to getting out of bed."

On 7/20/17 at 9:10 a.m., LPN (licensed practical nurse) #3, a unit manager was interviewed. When asked if she knew why Resident #11 had a physician's order for daily weights, LPN #3 stated: "He will start increasing (weight) really fast. He has heart failure." When asked who is responsible for reporting a daily weight gain of greater than two pounds to the physician or NP, LPN #3 stated: "The floor nurse is responsible."

On 7/20/17 at 9:50 a.m. at 9:50 a.m., LPN #6 was interviewed. She stated the aides are responsible for obtaining the daily weights and writing the weights on the residents' ADL (activities of daily living) sheets. She stated the floor nurse is responsible for checking the resident's weight against the previous weights and to notify the physician or NP if applicable. LPN #6 stated the notification of the physician should be

F 157 3. What measures will be put into place or systematic changes made to ensure the practice will not reoccur.

All license nurses will be educated by 8-14-17 by Staff Development Coordinator, Unit managers and/or Director of Nursing on physician notification/change of condition as directed by physician's orders and change of condition policy to include weight loss, weight gains per physician's orders.

All nurses will be education by 8-14-17 by Staff Development Coordinator/Unit managers or Director of nursing on utilizing of standing orders for O2 to notify Physician and Family Nurse Practioner of resident's condition and orders written per standing orders. Notification will be documented in the nurse's notes.

Any licensed nurse that has not been Inserviced by 08/14/17 will not be Allowed to provide direct care until Inservice is completed. All newly hired Nurses will receive education during Orientation.

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documented either on the back of the TAR or in the nurses' notes. When asked to review the TARs and nurses' notes for Resident #11 regarding the daily weights, LPN #6 stated: "No. It doesn't look like anyone was notified on those dates."

On 7/20/17 at 10:00 a.m. LPN #3, a unit manager, was interviewed. LPN #3, stated: "There is no evidence of the physician being notified on the dates you pointed out."

On 7/10/17 at 10:10 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. Policies regarding physician notification of a change in a resident's condition were requested.

A review of the facility policy "Change in a Resident's Condition" revealed, in part, the following: "The attending physician will be notified of any incident, accident, or change in the resident's medical condition."

No further information was provided prior to exit.

According to Basic Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), "Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient."

Director of Nurse's and/or Unit managers in grand rounds will audit daily and weekly weights, and physician or family nurse practionier notification 5 times a week for 30 days, then three times a week for 30 days and 1 time a week for one month.

Director of Nurse's and/or Unit managers will audit in grand rounds any new oxygen orders from standing orders and notification to physician and family nurse practionier of change in condition and need for standing orders.

4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur?

Director of nurse's will present findings of audits for weight loss, weight gain and o2 to the Quality Assurance /Performance Improvement committee for review and recommendations for 90
The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.

08/23/17

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2. The facility staff failed to notify the physician of weight loss of more than four pounds in one week, and of a refusal to be weighed in June 2017 for Resident #3.

Resident #3 was admitted to the facility on 2/23/17 and most recently readmitted on 6/1/17 with diagnoses including, but not limited to: history of bladder and kidney cancer, heart attack and right above the knee amputation. On the most recent MDS (minimum data set), a 14 day Medicare assessment with an assessment reference date of 6/15/17, Resident #3 was coded as having no cognitive impairment for making daily decisions.

A review of Resident #3's clinical record revealed the following physician's order dated 6/1/17 and signed by the physician on 6/26/17: "Weekly weight on Mondays. Notify MD/NP (medical doctor/nurse practitioner) of wt (weight) 4 lb (pounds) or greater in a week. Weekly."

A review of Resident #3's weekly weights revealed, in part, the following:
- 6/12/17 - 124
- 6/19/17 - 116
- 6/26/17 - Refused

Further review of Resident #3's clinical record, including the back of the TARs (treatment administration records) and nurses' notes, failed to reveal evidence that the facility staff notified the physician or NP of the weight loss and refusal to be weighed on the above referenced dates.

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A review of Resident #3's comprehensive care plan dated 6/1/17 revealed, in part, the following: "Weigh and observe results."

On 7/20/17 at 8:15 a.m., LPN (licensed practical nurse) #4, a unit manager, was interviewed. When asked if he knew why Resident #3 had a physician's order for weekly weights, LPN #4 stated: "Weekly weights are part of the NAR (nutritionally at risk). It was because of the possibility of weight loss." When asked who monitors residents' weekly weights, he stated that he, the dietary manger, the other unit manager, and at least one speech therapists meet weekly to discuss residents who are at risk of nutritional compromise and weight loss. When asked who is responsible for following the physician's order to notify the physician of a weight loss of greater than four pounds in a week, LPN #4 stated: "The unit managers are responsible. I was responsible." When asked if a physician should be notified if a resident with an order for weekly weights refuses to be weighed, LPN #4 stated: "Absolutely." LPN #4 was asked to check to see if he could locate evidence that the physician was notified of the above instances of weight loss and the refusal to be weighed. LPN #4 returned to the surveyor at 9:10 a.m. and stated: "I could not find any evidence of the notification. It should have been done."

On 7/20/17 at 10:00 a.m. LPN #3, a unit manager, was interviewed. LPN #3 stated: "There is no evidence of the physician being notified on the dates you pointed out."

On 7/20/17 at 10:10 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of

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these concerns.

No further information was presented prior to exit.

3. The facility staff failed to notify the physician/nurse practitioner when oxygen was initiated for Resident #8.

Resident #8 was admitted to the facility on 7/6/17. Resident #8's diagnoses included but were not limited to: diabetes, congestive heart failure and a diabetic foot ulcer. Resident #8's admission MDS (minimum data set) was not complete. An initial data collection tool dated 7/6/17 documented Resident #8 was alert and oriented. The tool further documented the resident was on room air (not receiving oxygen).

Review of Resident #8's clinical record revealed standing orders signed by the physician on 7/6/17. The standing orders documented, "Oxygen Orders: O2 (oxygen) at 2 Liters via nasal cannula or facemask PRN (as needed) for O2 saturation less than 90% or signs/symptoms of respiratory distress and call MD (medical doctor)/NP (nurse practitioner)..."

Review of nurses' notes revealed Resident #8 was on room air from 7/6/17 until 7/9/17. A nurse's note dated 7/9/17 documented Resident #8's oxygen saturation was 90% on two liters of oxygen. The note failed to document the MD or NP was made aware of oxygen administration to Resident #8 although the NP had been notified regarding the resident's increased temperature and another concern.

Resident #8's July 2017 MAR (medication administration record) and TAR (treatment

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administration record) failed to document information regarding oxygen. Resident #8's interim care plan initiated on 7/6/17 failed to document information regarding oxygen. The resident's comprehensive care plan was not complete.

On 7/20/17 at 1:25 p.m. an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was shown Resident #8's standing orders for oxygen. LPN #4 was asked if the MD or NP should be notified if oxygen was initiated. LPN #4 stated, "Yes ma'am." LPN #4 was asked where the notification should be documented. LPN #4 stated the notification should be documented in the nurse's notes. The nurse's note dated 7/9/17 was reviewed with LPN #4. LPN #4 stated he did not see documentation that the MD or NP was notified when Resident #8's oxygen was initiated.

On 7/20/17 at 2:15 p.m., an interview was conducted with ASM (administrative staff member) #3 (the nurse practitioner). ASM #3 stated she knew of Resident #8 but was less familiar with him than other residents. ASM #3 stated she hadn't evaluated Resident #8 and no one had notified her regarding the initiation of Resident #8's oxygen.

On 7/20/17 at 2:18 p.m. an interview was conducted with RN (registered nurse) #1 (the nurse who documented Resident #8 was administered oxygen on 7/9/17). RN #1 stated she believed Resident #8 was already receiving oxygen on 7/9/17 so she did not notify the MD or NP.

On 7/20/17 at 2:25 p.m. ASM #1 (the executive director) and ASM #2 (the director of nursing)

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were made aware of the above findings.

The facility policy titled, "Change in a Resident's Condition" documented, "1. All changes in the resident's condition will be recorded in the resident's medical record. Such changes or conditions include, but are not limited to: Any accident/incident involving the resident. Any change in the resident's mental, physical, or emotional status. 2. The attending physician will be notified of any incident, accident, or change in the resident's medical condition..."

No further information was presented prior to exit.
4. The facility staff failed to notify the physician, per the physician orders, of a weight gain of over two pounds in a day for Resident #1.

Resident #1 was admitted to the facility on 12/28/17 with a recent readmission on 5/30/17, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), severe peripheral artery disease (any abnormal condition affecting the arteries outside the heart (2)) above the knee amputation, atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)), cardiac disease, aneurysm (a saclike widening in a blood vessel (4)), gastrointestinal bleed and osteoarthritis (the most common form of arthritis occurring mostly in the elderly, characterized by degenerative changes in the joints (5)).

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The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 5/11/17, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating he was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living, except eating in which he required supervision of one staff member.

The physician order dated, 5/4/17 and when readmitted rewritten on 5/30/17, documented, "Daily weight, if gains 2 lbs. (pounds) or more in a day, notify MD/NP (medical doctor/nurse practitioner). Provide copy of weights to MD/NP weekly on Wednesday, daily."

The May 2017 TAR (treatment administration record) documented, "Daily weight, if gains 2 lbs. or more in a day, notify MD/NP. Provide copy of weights to MD/NP weekly on Wednesday, daily." The weights were documented as ordered daily. The weight documented on 5/4/17 - 125.3 (pounds). The weight documented on 5/5/17 - 129.3 lbs. A weight gain of four pounds. The weight documented on 5/14/17 - 127.9. The weight documented on 5/15/17 - 135.9, a weight gain of eight pounds. Review of the reverse side of the TAR did not evidence any documentation of notification to the physician per the physician order for a weight gain of greater than two pounds in one day.

Review of the nurse's notes for 5/5/17 and 5/15/17 failed to evidence any documentation of notification of Resident #1's weight gains to the physician or nurse practitioner.

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The June 2017 TAR documented, "Daily weight, if gains 2 lbs. or more in a day, notify MD/NP. Provide copy of weights to MD/NP weekly on Wednesday, daily." The weights were documented as ordered daily. The weight documented on 6/29/17 - 131.5 (pounds). The weight documented on 6/30/17 - 134.8; a weight gain of 3.3 lbs. Review of the reverse side of the MAR did not evidence any documentation of notification to the physician per the physician order for a weight gain of greater than two pounds in one day.

A review of the nurse's notes for 6/30/17 failed to evidence any documentation of notification to the physician or nurse practitioner for Resident #1's weight gain as documented above.

The comprehensive care plan dated, 12/28/16 and revised on 4/26/17, documented in part, "Problem: Resident is at risk for cardiac distress due to Dx (diagnosis) of CAD (coronary artery disease), HTN (high blood pressure) and A. Fib (atrial fibrillation)." The "Approaches" documented in part, "Monitor vital signs as indicated, notify MD/NP and family of significant change as needed, and weigh as per protocol."

An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/19/17 at 1:47 p.m. regarding physician orders for notification of a residents two pound weight gain in a day. LPN #3 stated, "We have to get the daily weight and then compare it with the previous day's weight and notify the doctor or NP if there is a weight gain of greater than two pounds and document it." When asked where the notification should be documented, LPN #3 stated, "It could be on the back of the TAR or in a nurse's note."

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An interview was conducted with LPN #9 on 7/19/17 at 3:15 p.m. When asked why a physician would order daily weights and to be notified if there is a weight gain of two pounds or more in a day, LPN #9 stated, "We have to notify them because a weight gain could be related to fluid retention."

The facility policy, "Change in a Resident's Condition" documented in part, "1. All changes in the resident's condition will be recorded in the resident's medical record. Such changes or conditions include, but are not limited to: any accident/incident involving the resident and any change in the resident's mental, physical, or emotional status. 2. The attending physician will be notified of any incident, accident, or change in the resident's medical condition. "

The executive director and the director of nursing were made aware of the above findings on 7/19/17 at 5:18 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 447.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 34.
(5) Barron's Dictionary of Medical Terms for the

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Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 422.

F 167 SS=C 483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE

(g)(10) The resident has the right to-

(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and

(g)(11) The facility must--

(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.

(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and

(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

(iv) The facility shall not make available identifying information about complainants or residents.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview it was determined that the facility staff failed to post a notice of the availability of the preceding three years of survey results for review by residents

F 157

F 167

F-167

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Executive Director had state book labeled on 7-18-17 to reflect that it has 3 years of state survey results available with plan of correction to residents and responsible parties for review.

2. How will the facility identify other residents having the potential to be affected by the same practice? Social Services will notify resident counsel by 8-5-17 of where 3 years of facility surveys with plans of correction can be found for review.

Posting by Executive Director 7-18-17 of notice of availability of the last 3 years of survey and plan of correction for residents and responsible parties.

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F 167	Continued From page 14 and RPs (responsible parties). A notice was not posted to the residents and responsible parties that the results of the prior three years of survey results, with the plan of corrections, were available for review. The findings include: On 7/19/17 at 8:30 a.m. and 7/20/17 at 12:15 p.m. the results of the surveys for the previous three years were observed in a binder on the wall across from the dining room. A sign above the binder stated: "Current state survey results." The sign failed to inform residents and RPs that the results of the prior three years of survey results were available for review. On 7/20/17 at 12:20 p.m., ASM (administrative staff member) #1, the executive director was interviewed. When asked what was required for signage regarding the availability of survey results, ASM #1 stated: "There has to be a notice about where the results are located." When asked if he was aware that the notice has to state that three years of survey results are available for review, ASM #1 stated: "To be honest, no." He stated that he had only been at the facility for a matter of days, and that he had been told that the survey posting had been taken care of prior to his arrival. On 7/20/17 at 3:00 p.m., a policy was requested regarding survey posting. No further information was provided prior to exit.	F 167	 3. Executive Director will check 3 times a week for one month to assure book notification has 3 years of surveys with plan of correction and is available to residents and visitors. Then weekly for 2 months. 4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur? Executive Director will report findings of audits monthly for 90 days to the Quality Assurance/Performance Improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nurse's, Assistant Director of Nurse's, Social Services, Activities, Dietary Manager, Medical Director, Pharmacy Consultant. 8/29/17	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 15 483.20 (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). (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	F 279	F-279 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident # 9 care plan was updated by LPN (Unit Manager) nurse on 8-2-17 to reflect diuretic use and approaches for care. 2. How will the facility identify other residents having the potential to be affected by the same practice? On 8-1-17 Unit managers reviewed all residents on diuretic for comprehensive care plans addressing diuretic use and approaches for care. Any resident found not to have a current comprehensive care plan for diuretic use and approaches for care was updated by unit managers on 8-2-17	

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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 the facility staff failed to develop a comprehensive care plan for one of 29 residents in the survey sample, Resident #9.

The facility staff failed to develop a comprehensive care plan for Resident #9's use of diuretics (medications used to eliminate fluid from the body) coded on her 5 day admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 6/13/17, in Section N, Medications, which was coded as being administered for seven days during the look back period.

The findings include:

3. What measures will be put in place or systematic changes made to ensure the practice will not reoccur.

By 8-14-17 Staff Development Coordinator, Director of Nursing, and /or Unit managers will educate on implementing and revising care plans for diuretic use and approaches for care.

Any licensed nurse that has not been Inserviced by 08/14/17 will not be Allowed to provide direct care until Inservice is completed. All newly hired Nurses will receive education during Orientation.

All new admissions / re-admissions and telephone order will be reviewed in grand rounds (am clinical meeting) by Director of Nurse's and/or unit managers five days a week for 30 days / three times a week for 30 days and weekly for 30 days for comprehensive care plans for diuretic use and approaches for care of a resident on diuretics.

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Resident #9 was admitted to the facility on 6/6/17 with the following diagnoses; cellulitis (a skin infection) of both lower legs, metabolic encephalopathy (a swelling of the brain), high blood pressure, dementia and congestive heart failure.

Resident #9's most recent MDS (minimum data set), a 5 day assessment, with an ARD (assessment reference date) of 6/13/17 coded Resident #9 as scoring a 12 out of a possible 15 on the BIMS (brief interview for mental status), indicating that Resident #9 was moderately cognitively impaired with daily decision making. In section N, Medications, Resident #9 was coded as receiving a diuretic for seven days during the seven day look back period.

A review of Resident #9's comprehensive care plan dated 6/6/17 did not document any information regarding a diuretic and the approaches for care when a resident is on a diuretic.

A review of Resident #9's MAR (medication administration record) dated July 2017 revealed, in part, the following order, "6/6/2017. Lasix (a diuretic medication (1)) 20 mg (milligrams) tablet PO (by mouth) daily CHF (congestive heart failure) Generic: furosemide (Lasix)." The medication was signed off on each day in July as administered daily at 9:00 a.m.

An interview was conducted with LPN (licensed practical nurse) #9, the MDS coordinator on 7/19/17 at 3:15 p.m. LPN #9 was asked whether or not medications listed in Section N, Medications should be care planned. LPN #9

4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur?

The Director of Nursing will present findings of comprehensive care plans for diuretic use to the Quality Assurance /Performance Improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nurse's, Assistant Director of Nurse's, Social Services, Activities, Dietary Manager, Medical Director, Pharmacy Consultant.

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stated that they should all be care planned if listed in Section N on the MDS. LPN #9 was shown Section N on Resident #9's MDS with an ARD of 6/13/17. LPN #9 was asked if diuretics, listed in Section N, should have been care planned. LPN #9 stated that she would like to review the care plan more closely. LPN #9 reviewed Resident #9's care plan and stated, "I cannot find a care plan on diuretics." LPN #9 further stated that it was not done.

A meeting was held on 7/20/17 at approximately 10:00 a.m. with ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above findings and a policy was requested on developing a comprehensive care plan.

A review of the facility document "Care Planning and Interventions" revealed, in part, the following; "Standard: The interdisciplinary team meets on a scheduled basis and develops an individualized care plan."

No further information was provided prior to the end of the survey process.

(1) Lasix (also known as furosemide) helps your body get rid of extra water by increasing the amount of urine you make. Getting rid of extra water decreases the strain on your heart and blood vessels, thereby lowering high blood pressure and reducing your risk of strokes, heart attacks, and kidney problems. This information was obtained from the following website; http://reference.medscape.com/drug/lasix-furosemide-342423#91

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F 280 SS=D	Continued From page 19 F 280 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280 F 280	RECEIVED AUG 07 2017 VDH/OLC F-280	

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.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

Resident #1 comprehensive care plan was reviewed and revised by LPN (Unit Manger) and updated on 7-20-17 to reflect use of oxygen administration.

Resident # 8 has been discharged from facility 7-20-17.

2. How will the facility identify other residents having the potential to be affected by the same practice?

On 8-2-17 all residents who are receiving O2 administration comprehensive care plans were reviewed by the unit managers for O2 administration and care plans were revised as needed.

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(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.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the

3. What measures will be put in place or systematic changes made to ensure the practice will not reoccur.

By 8-14-17 Staff development coordinator, Director of Nursing and/or unit managers will educate nurses on updating and revising care plans for O2 use.

Any licensed nurse that has not been Inserviced by 08/14/17 will not be Allowed to provide direct care until Inservice is completed. All newly hired Nurses will receive education during Orientation.

All residents in grand rounds (am clinical meeting) with new orders for O2 administration will be audited by Director of Nurse's and/or Unit managers for interim and comprehensive care plans for O2 administration 5 times a week for 30 days, then 3 times week for 30 days, then 1 time a week for 30 days.

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comprehensive and quarterly review assessments.
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 review and revise the comprehensive care plan for two of 29 residents in the survey sample, Residents #1 and #8.

1. The facility staff failed to review and revise Resident #1's comprehensive care plan regarding oxygen administration.

2. The facility staff failed to review and revise Resident #8's comprehensive care plan regarding the initiation and administration of oxygen.

The findings include:

1. Resident #1 was admitted to the facility on 12/28/17 with a recent readmission on 5/30/17, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), severe peripheral artery disease (any abnormal condition affecting the arteries outside the heart (2)) above the knee amputation, atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)), cardiac disease, aneurysm (a saclike widening in a blood vessel (4)), gastrointestinal bleed and osteoarthritis (the most common form of arthritis occurring mostly in the elderly, characterized by degenerative changes in the

4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur?

The Director of Nurse's will present findings of audits for comprehensive care plans for O2 administration to the Quality Assurance/Performance Improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nurse's, Assistant Director of Nurse's, Social Services, Activities, Dietary Manager, Medical Director, Pharmacy Consultant.

08/23/17

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joints (5)).

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 5/11/17, coded Resident #1 as scoring a 13 on the BIMS (brief interview for mental status) score, indicating he was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living, except eating in which he was coded as requiring supervision of one staff member. In Section O - Special Treatments, Procedures, and Programs" Resident #1 was coded as using oxygen during the look back period.

The physician order dated, 5/30/17 documented in part, "O2 (oxygen) 3 L (liters) nc (nasal cannula) continuously TID (three times a day)."

Observation was made of Resident #1 on 7/18/17 at 1:20 p.m. The resident was in bed with his oxygen on via a nasal cannula (a plastic tube with prongs that rest just inside the nose) connected to an oxygen concentrator. The oxygen concentrator was observed with the flow meter ball sitting between the 3.0 and 3.5 L/Min (liters per minute) rate. Resident #1 was again observed on 7/19/17 at 7:38 a.m., 9:55 a.m. and 1:34 p.m., during each observation the flow rate was set with the ball between the 3.0 and 3.5 L/Min flow rate. On 7/20/17 at 8:28 a.m. Resident #1 was observed in bed with his oxygen in place. The concentrator was set with the flow rate ball between the 3.0 and 3.5 L/Min flow rate. This observation was confirmed by another surveyor.

Review of the comprehensive care plan did not

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reveal any documentation regarding the use and care of oxygen for Resident #1 on the care plan.

An interview was conducted with LPN (licensed practical nurse) #14 on 7/20/17 at 1:14 p.m. When asked if oxygen usage should be included on the care plan, LPN #14 stated, "Yes." When asked who is responsible for updating the care plan, LPN #14 stated, "The nurses do not update the care plan, it's normally the unit manager and MDS."

An interview was conducted with LPN #3, the unit manager, on 7/20/17 at 1:16 p.m. When asked if oxygen usage should be included on the care plan, LPN #3 stated, "Yes." LPN #3 was asked to review Resident #1's care plan. When asked if she saw oxygen documented on the care plan, LPN #3 stated, "It's not there. No Ma'am." When asked who is responsible for updating the care plan, LPN #3 stated, "That should have been caught when he came back from the hospital. The nurse admitting him should have put it on the care plan."

The facility policy, "Care Planning and Interventions" documented in part, "The care plan is updated as needed, but no less than quarterly as: conditions change, goals are not met, and interventions are determined to be ineffective or need to be revised."

The executive director, ASM (administrative staff member) #1 and ASM #2, the director of nursing, were made aware of the above findings on 7/20/17 at 4:05 p.m.

No further information was provided prior to exit.

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(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 447.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 34.
(5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 422.
2. The facility staff failed to review and revise Resident #8's comprehensive care plan regarding the initiation and administration of oxygen.

Resident #8 was admitted to the facility on 7/6/17. Resident #8's diagnoses included but were not limited to: diabetes, congestive heart failure and a diabetic foot ulcer. Resident #8's admission MDS (minimum data set) was not complete. An initial data collection tool dated 7/6/17 documented Resident #8 was alert and oriented. The tool further documented the resident was on room air (not receiving oxygen).

Review of Resident #8's clinical record revealed standing orders signed by the physician on 7/6/17. The standing orders documented, "Oxygen Orders: O2 (oxygen) at 2 Liters via nasal cannula or facemask PRN (as needed) for O2 saturation less than 90% or signs/symptoms of respiratory distress and call MD (medical doctor)/NP (nurse practitioner)..."

Review of nurses' notes revealed Resident #8

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was on room air from 7/6/17 until 7/9/17. A nurse's note dated 7/9/17 documented Resident #8's oxygen saturation was 90% on two liters of oxygen. Resident #8's interim care plan initiated on 7/6/17 failed to document information regarding oxygen. The resident's comprehensive care plan was not complete.

On 7/20/17 at 1:25 p.m. an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked if a resident's care plan should be updated if oxygen is initiated. LPN #4 stated the care plan should be updated and should include the liters per minute that is to be administered, whether a nasal cannula or facemask should be used and if the oxygen is continuous or as needed. LPN #4 stated the nurse who initiates the oxygen can update the care plan.

On 7/20/17 at 2:25 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Care Planning and Interventions" documented, "The care plan is updated as needed, but no less than quarterly as: Conditions change..."

No further information was presented prior to exit.

F 281 SS=E 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS — F 281

(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan,

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F 281	Continued From page 26 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for four of 29 residents in the survey sample, Resident #25, #9, #17 and #3. 1. The facility staff performed a bowel disimpaction on Resident #25 without an order from a physician. 2. The facility staff failed to clarify a pain medication order that did not contain parameters for Resident #9. 3. The facility staff failed to clarify pain medication orders that did not contain parameters for Resident #17. 4. The facility staff failed to clarify the parameters for Resident #3's pain medication orders. The findings include: 1. The facility staff performed a bowel disimpaction on Resident #25 without an order from a physician. Resident #25 was admitted to the facility on 6/16/17 with diagnoses that included, but were not limited to; high blood pressure, diabetes, low blood pressure, chronic kidney disease, obesity and hemorrhoids.	F 281	F-281 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Physician was notified that resident had been dis-impacted on 7-20-17. Physician completed physical assessment of resident on 7-20-17. On 7-22-17 resident had order for continued use of hemorrhoid crème prn. Nurse # 13 was suspended on 7-20-17 and corrective action was completed 7-31-17. Nurse #13 was directed to review Virginia scope of practice for licensed nurses. She was placed on an action plan to include re-orientation from 7-25-17 through 7-31-17. Staff development coordinator educated nurse #13 on change of condition and notification to physician for concerns of hemorrhoids, constipation unrelieved by bowel protocol and rectal pain and nurses are not to dis-impact residents.	RECEIVED AUG 07 2017 VDH/OLC

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Resident #25's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/13/17, coded Resident #25 as scoring a 14 out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #25 is cognitively intact. Resident #25 was also coded as requiring maximum assistance of one person for toileting.

On 7/18/17 at 3:30 p.m. an interview was conducted with Resident #25. Resident #25 was tearful and stated that she suffered from hemorrhoids, that she was recently at her surgeons office for an unrelated reason and that he had told her that she needed to be on a stool softener. Resident #25 stated that she did not get the stool softener for several days and as a consequence she stated "I got so packed up I couldn't stand it, the nurse had to pull it out. I didn't even know you could do that." Resident #25 further stated, "I got chills and had to stay in the bed all day. Now every time I have a bowel movement I am on fire, I have begged for a salve (ointment for the rectum) but they (nursing) say then don't have any. I've been using something else to help with the burning." When asked if the doctor or nurse practitioner had assessed her hemorrhoids Resident #25 stated no.

A review of Resident #25's clinical record did not reveal any nursing progress notes that referenced disimpaction or Resident #25's concern for constipation.

A review of Resident #25's physician orders revealed the following; "7/14/17 11:50 a.m. Prep (preparation) H (an ointment used to treat hemorrhoids) ointment to hemorrhoids BID (two times per day) x (for) 1 (one) wk (week). D/C

F 281 Resident # 9 Pain medication order was obtained by LPN (Unit Manager)on 8-2-17 to include parameters for pain medication administration.

Resident # 17 Pain medication orders was obtained by LPN (Unit Manager) on 8-2-17 to include parameters for pain medication administration.

Resident # 3 Pain medication orders was obtained by LPN (Unit Manager) on 8-2-17 to include parameters for pain medication administration.

2. How will the facility identify other residents having the potential to be affected by the same practice?

All other residents using hemorrhoid crèmes were audited by unit manager on 8-2-17 for dis-impaction. Only one other resident 13123 receiving hemorrhoid crème. Resident has not been dis-impacted.

All residents on PRN pain medications were audited for parameters by unit managers on 8-2-17. All residents that did not have parameters were reviewed with physician by unit manager and new orders given for pain medication parameters. Unit manager wrote new orders on Medication administration sheets on 8-2-17.

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(discontinue) fiber laxative. Colace 100 mg (milligrams) PO (by mouth) daily for stool softener. Fiber laxative 2 (two) tabs (tablets) po qhs (every bedtime) impaction."

A review of Resident #25's MAR (medication administration record) dated July 2017 revealed, in part, the following entries; "Fiber laxative (an over the counter supplement to help reduce constipation) Take 2 tabs (tablets) PO QHS dx. (diagnosis) Impaction." From 7/14/17 through 7/19/17 there were nurses initials documented indicating this was administered at 9:00 p.m. each evening. "Colace (a stool softener) 100 mg (abbreviation for 1) PO daily Dx. Constipation." From 7/15/17 through 7/20/17 there were nurses initials documented indicating this was administered at 9:00 a.m. each day. There were no order entries or nursing initials for preparation H to be applied to the hemorrhoids.

A review of Resident #25's comprehensive care plan dated 6/16/2016 revealed, in part, the following documentation; "Problems: Resident is at risk for pain. Approaches: Observe for s/s (signs and symptoms) constipation and administer bowel protocol PRN (as needed)." Further review did not reveal any documentation regarding hemorrhoids.

On 7/20/17 an interview was conducted with LPN (licensed practical nurse) #13, a floor nurse working with Resident #25. LPN #13 was asked what should be done if a resident states he/she is constipated. LPN #13 stated, "If I don't have an order for laxatives then I ask the nurse practitioner for an order." LPN #13 was asked what should be done if a resident states that he/she is unable to evacuate their bowels. LPN

F 281

3. What measures will be put in place or systematic changes made to ensure the practice will not reoccur.

Nurses will be educated by the Staff Development Coordinator, Director of Nursing on nursing standards of practice by 8-14-17. No residents are to be dis-impacted. Physician to be notified of any change with GI status involving need for dis-impaction, unrelieved constipation with current bowel regimen or treatment for hemorrhoids.

BM report will be printed five times a week by the unit manager for review for frequency of BMS. 24 hour report will be reviewed daily for any complaints of unrelieved constipation with current bowel regimen or hemorrhoids with rectal pain during grand rounds (am clinical meeting). Audit will occur during grand round (am Clinical meeting). Follow up for MD notification will be audited. Five times a week for 30 days/3 times a week for 30 days and 1 time a week for 30 days.

Nurses will be educated on writing orders for pain medications with parameters by Staff Development Coordinator/Director of nursing by 8-14-17.

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#13 stated that normally she would go back to the nurse practitioner. LPN #13 was asked if she would normally attempt to disimpact the resident. LPN #13 responded, "No but one resident did recently beg me to do that (disimpact), (name of Resident #25)." LPN #13 stated that this happened on 7/14/17. LPN #13 was asked if she obtained an order to disimpact Resident #25, LPN #13 stated that she mentioned it to (name of nurse practitioner) and received an order for a stool softener. LPN #13 was asked if she was aware of Resident #25 having hemorrhoids. LPN #13 stated that she was. LPN #13 was asked if Resident #25 complained to her of her bottom being sore following the disimpaction, LPN #13 stated, "She said it burned when she pooped." LPN #13 was asked if she had anyone assess Resident #25's bottom related to her ongoing complaints. LPN #13 stated that she did not. When asked if she had looked at the hemorrhoids, LPN #13 stated, "I did look at the hemorrhoids and they were very swollen." LPN #13 was asked if she documented about the disimpaction or the assessment she had done, LPN #13 stated that she did not.

On 7/20/17 at 1:55 p.m. an interview was conducted with ASM (administrative staff member) #3, the nurse practitioner. ASM #3 was asked if LPN #13 had approached her on 7/14/17 about Resident #25 being very constipated, and was asked if LPN #13 had received a verbal order to disimpact Resident #25. ASM #3 stated that she had not worked on 7/14/17 and that (name of ASM #5, the medical doctor) was working on his own that day. ASM #3 further stated that (name of Resident #25) had stopped her in the hall on the following Tuesday (7/18/17) and told her that a "nurse" had to "dig out" the

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All orders for pain management with parameters will be audited by Director or nurses and/or unit managers in grand rounds (am Clinical meeting) to ensure parameters are included in the orders.

Any licensed nurse that has not been Inserviced by 08/14/17 will not be Allowed to provide direct care until Inservice is completed. All newly hired Nurses will receive education during Orientation.

4. How will the facility monitoring the corrective plan to ensure the deficient practice was corrected and not reoccur?

The Director of nursing will present findings of audit for GI status changes and pain management to include parameters for pain medication administration to the Quality Assurance/Performance Improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nurse's, Assistant Director of Nurse's, Social Services, Activities, Dietary Manager, Medical Director, Pharmacy Consultant.

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stool. When asked if ASM #3 conducted an examination after what Resident #25 had told her, ASM #3 stated that she had not. ASM #3 was asked if she was aware of an order for Resident #25 to be disimpacted, ASM #3 stated no. ASM #3 further stated, "I did not know that nursing could even do that. I would want to assess the resident before doing a disimpaction and then reassess after the disimpaction."

On 7/20/17 at 2:30 p.m. an interview was conducted with ASM #5, the medical doctor. ASM #5 was asked if he had given a verbal order to disimpact Resident #25 on 7/14/17. ASM #5 stated, "I remember the nurse coming to me, but I don't remember her asking about disimpacting. We do not normally do that. I can't remember the last time that happened." ASM #5 was asked if the nurse came back to him to let him know that Resident #25 was in pain following the disimpaction. ASM #5 stated, "I remember that the nurse said she (Resident #25) was impacted and not that she had disimpacted her. I wrote orders for stool softeners. I can't say what else happened. I don't know."

On 7/20/17 at 3:00 p.m. an interview was held with ASM #2, the director of nursing, and LPN #13. ASM #2 was made aware of the concern of LPN #13 performing a disimpaction on Resident #25 without a physician order. ASM #2 verified that a physician order would have to be obtained for the procedure and should not have been done without an order. At this time a policy was requested for disimpacting residents and obtaining physician orders to disimpact a resident.

A review of the facility document titled "Physician

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LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

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Orders" revealed, in part, the following documentation; "Policy: A physician must provide orders for the resident's immediate care. Procedure: Physician orders include the following; Special medical procedures required for the safety and well-being of the resident. Note: Medications, diets, therapy and any treatment may not be administered to the resident without a written order from the attending physician."

No further information was provided prior to the end of the survey process.

2. The facility staff failed to clarify a pain medication order that did not contain parameters for Resident #9.

Resident #9 was admitted to the facility on 6/6/17 with the following diagnoses; cellulitis (a skin infection) of both lower legs, metabolic encephalopathy (a swelling of the brain), high blood pressure, dementia and congestive heart failure.

Resident #9's most recent MDS (minimum data set), a 5 day assessment, with an ARD (assessment reference date) of 6/13/17 coded Resident #9 as scoring a 12 out of a possible 15 on the BIMS (brief interview for mental status), indicating that Resident #9 is moderately cognitively impaired with daily decision making. In Section J, Health Conditions, Resident #9 was coded as having pain frequently with a worst pain coded as a "6" (six) out of a possible 10 in the past five days.

A review of Resident #9's hospital discharge summary dated 6/6/2017 revealed, in part, the

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following medications to be continued at the facility; "HYDROcodone-acetaminophen (1) 5-325 MG (milligrams) per tablet. Commonly known as: NORCO (1) Take 1 (one) tablet by mouth every 4 (four) hours as needed for pain. Acetaminophen (sic) 325 MG tablet. Commonly known as: Tylenol [2]."

A review of Resident #9's MAR (medication administration record) dated July 2017 documented, in part, the following entries;

- "6/6/2017 acetaminophen 325 mg tablet take 2 tab - 650 mg PO (by mouth) every 4 hours as needed." Nurses' initials were documented under the following dates; 7/1/17, 7/2/17, 7/4/17, 7/5/17, 7/7/17 and 7/10/17, indicating administration of this medication.
- "6/6/2017 Norco 5 mg-325 mg tablet take 1 tab PO every 4 hours as needed pain. Generic: hydrocodone-acetaminophen." Nurses' initials were documented under the following dates; 7/3/17, 7/4/17, 7/9/17, 7/14/17, 7/15/17, 7/16/17 and 7/17/17, indicating administration of this medication.

A review of Resident #9's Pain Flow Sheet revealed, in part, entries for the following dates;
- "7/9/17 Site: legs. Type: A (aching) Current Intensity: 5/10. Medication/Dose: Norco 1."
- "7/14/17 Site: legs. Type: A. Current Intensity: 5/10. Medication/Dose: Norco x 1 (one tablet."
- "7/17/17 Site: legs. Type; A. Current Intensity: 5/10. Medication/Dose: Norco x 1."
- "7/17/17 Site: Back. Type. A. Current Intensity: 5/10. Medication/Dose: Norco x 1."

Further review of Resident #9's clinical record did not reveal orders for nursing to determine under

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what circumstances acetaminophen should be given for pain and when Norco should be administered.

A review of Resident #9's comprehensive care plan dated 6/6/2017 revealed, in part, the following documentation; "Onset date 6/6/2017. Problems: Resident is at risk for pain Relating To generalized discomforts, recent hardware removal, cellulitis. Approaches: Administer/observe for effectiveness and for possible side effects from pain medication. PRN pain medication."

On 7/19/17 at 3:15 p.m. an interview was conducted with LPN (licensed practical nurse) #9, the MDS coordinator. LPN #9 was asked how nursing should determine which pain medication, Tylenol versus Norco, should be given. LPN #9 stated that it would depend on the pain level and that nursing should administer the least amount of medication that is effective. LPN #9 further stated, "If a resident is cognitively intact I let them choose, but if the resident is unable to say then I will choose. The pain medication is determined on how that nurse interprets the pain."

On 7/20/17 at 8:30 a.m., LPN #4, a unit manager, was interviewed. When shown the two orders for prn pain medication, and asked which medicine should be given on any given occasion, LPN #4 stated: "These orders don't really say. These orders should have been clarified." LPN #4 pointed out that both medications could technically be given at the same time, according to the orders. LPN #4 stated he doubted that was the physician's intent, and that the orders should have been clarified.

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On 7/20/17 at 8:30 a.m. an interview was conducted with LPN (licensed practical nurse) #7, a floor nurse. LPN #7 was asked how she would determine which prn (as needed) pain medication she would choose to give if she had a choice of two medications, Tylenol and Norco. LPN #7 stated that if the pain rate was low then she would give the lower strength medication, the Tylenol. LPN #7 was asked what criteria she would use to determine her choice. LPN #7 stated that she would look at the resident and determine the better option. LPN #7 further stated, "It would be nice to have parameters."

On 7/20/17 at 10:15 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was made aware of the above concerns. When asked how nursing determines which pain medications to give, ASM #2 stated, "There should be parameters indicating which pain medication should be used for the type of pain being experienced." A policy was requested at this time on pain management.

A review of the facility document titled "Administration of Medication" revealed, in part, the following documentation; "Standard: All medications are administered safely and appropriately to help residents overcome illness, relieve/prevent symptoms and help in diagnosis. Policy: Responsibility of the nursing professional: be aware of the classification, action, correct dosage, and side effects of a medication before administration. A physician order that includes dosage, route, frequency, duration and other required considerations including the purpose, diagnosis or indication for use is required for administration of medication."

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No further information was provided prior to the end of the survey process.

(1) NORCO is indicated for the relief of moderate to moderately severe pain. This information was obtained from the following website; https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=aaef2d01-126d-4aab-9b2a-eee31a769150

(2) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever.
3. The facility staff failed to clarify pain medication orders that did not contain parameters for Resident #17.

Resident #17 was admitted to the facility on 6/15/13 with diagnoses that included but were not limited to: high blood pressure, abnormal posture, anemia, dementia, and osteoarthritis.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/15/17, coded the resident as scoring a two on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of her activities of daily living.

The physician order dated, 2/22/17 documented, "Norco (used to treat moderate to moderately severe pain (1)5/325 mg (milligrams) take one

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tab (tablet) every 4 hours for pain PO (by mouth) PRN (as needed) daily."

The physician order dated, 5/1/17 documented, "Tylenol (used to treat pain or fever (2)) 325 mg (milligrams) tablet take 650 mg by mouth every 4 hours as needed for pain or fever > (greater than) 100.7 PO PRN six times a day."

The April, May, June and July 2017 MAR documented the resident had received both of these medications.

The comprehensive care plan dated, 12/31/14 with a target date of 9/29/17, documented in part, "Problems: Resident is at risk for pain related to Dx (diagnosis) of arthritis, generalized discomforts." The "Approaches" documented in part, "Administer/observe for effectiveness and for possible side effects from PRN pain medication. Notify the resident's physician if they do not state/demonstrate relief or reduction of pain after one hour of receiving the first intervention."

An interview was conducted with LPN (licensed practical nurse) #8 on 7/20/17 at 12:22 p.m. LPN #8 was asked to review the Tylenol and the Norco orders. When asked how staff knows which medication to give for pain, LPN #8 stated, "I usually give her Tylenol first and go with a less potent first, if that's not effective, then I would give the Norco." When asked if the order says that, LPN #8 stated, "It's at the nurse's discretion." When asked if there should be a clarification of the orders for pain medication, LPN #8 stated, "There should be."

An interview was conducted with LPN #4, the unit

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manager; on 7/20/17 at 12:28 p.m. LPN #4 was asked to review the Tylenol and Norco orders. When asked how a nurse knows which medication to give for pain, LPN #4 stated, "It should be based on the nurse's assessment, if severe pain, go with the Norco." When asked if the order specifies what to give for mild or severe pain, LPN #4 stated: "These orders don't really say. These orders should have been clarified."

The facility policy, "Physician Orders" did not address the clarification of physician orders.

The executive director and director of nursing were made aware of the above findings on 7/20/17 at 4:05 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=aaef2d01-126d-4aab-9b2a-eee31a769150
(2) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=59282

4. The facility staff failed to clarify the parameters for Resident #3's pain medication orders.

Resident #3 was admitted to the facility on 2/23/17 and most recently readmitted on 6/1/17 with diagnoses including, but not limited to: history of bladder and kidney cancer, heart attack and right above the knee amputation. On the most recent MDS (minimum data set), a 14 day Medicare assessment with an assessment

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reference date of 6/15/17, Resident #3 was coded as having no cognitive impairment for making daily decisions. He was coded as having received pain medications during the look back period.

A review of the physician's orders for Resident #3 revealed the following orders written 6/1/17 and signed by the physician on 6/26/17: "Hydrocodone-acetaminophen (Vicodin (1)) 5-325 mg (milligrams). Take 1 tablet po (by mouth) q 4 hours prn pain...Tylenol 325 mg tablet. Take 2 Tabs (tablets) po q 6 hrs prn for pain or fever."

A review of the MARs (medication administration record) and pain flow sheets for Resident #3 revealed that Resident #3 received Vicodin nine times in June 2017. Further review of these documents revealed that Resident #3 received Tylenol three times in June 2017.

The review of the MARs and pain flow sheets for Resident #3 revealed that Resident #3 received Vicodin 12 times in July 2017. Further review revealed that Resident #3 did not receive Tylenol at all in July 2017 up to the time of the survey.

A review of Resident #3's comprehensive care plan dated 6/1/17 revealed, in part, the following: "Administer/observe for effectiveness and for possible side effects from pain medication, PRN pain medication, (see MAR)."

On 7/19/17 at 3:35 p.m., LPN (licensed practical nurse) #9, an MDS coordinator, was interviewed. LPN #9 was asked what a nurse should do if a resident has two different orders for prn pain medications, but has no parameters specifying when each medication should be given. LPN #9

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stated that nursing practice is to start with the least amount of medication needed to cover a resident's pain. LPN #9 stated: "It depends on the pain level." When asked who is responsible for determining which medication is given in any particular situation, LPN #9 stated: "The nurse who is giving it."

On 7/20/17 at 8:30 a.m., LPN #4, a unit manager, was interviewed. When shown the two orders for prn pain medication for Resident #3, and asked which medicine should be given on any given occasion, LPN #4 stated: "These orders don't really say. These orders should have been clarified." LPN #4 pointed out that both medications could technically be given at the same time, according to the orders. LPN #4 stated he doubted that was the physician's intent, and that the orders should have been clarified.

On 7/20/17 at 10:10 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. When asked what the facility follows as a standard of professional practice, ASM #2 stated the facility follows its policies and the content of the facility's online training. ASM #2 was asked to provide the survey team with policies and/or content of online training related to order clarification.

A review of the facility policies "Physician Orders" and "Administration of Medication" revealed no information related to clarification of physician orders. The facility staff did not provide any content of online training related to clarification of physician orders.

No further information was provided prior to exit.

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(1) "Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. Hydrocodone relieves cough by decreasing activity in the part of the brain that causes coughing." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601006.html.

The following information is provided in Fundamentals of Nursing, 6th edition (Potter and Perry, 2005, p.846): "A medication order is required for any medication to be administered by a nurse...If the medication order is incomplete, the nurse should inform the prescriber and ensure completeness before carrying out any medication order."

F 282 SS=D — 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN — F 282

(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and review of facility documentation it was determined the facility staff failed to follow the written plan of care for one of 29 residents in the survey sample, Resident #10.

The facility staff failed to provide pressure injury prevention treatment (protective boots) to Resident #10 per the resident's written plan of care.

The findings include:

Resident #10 was admitted to the facility on 1/4/16. Resident #10's diagnoses included but were not limited to: chronic kidney disease, high blood pressure and a history of a pressure ulcer of the right hip. Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/27/17, coded the resident's cognition as severely impaired. Section M documented Resident #10 was at risk of developing pressure injuries (1) but did not have any.

Review of Resident #10's clinical record revealed a Braden scale for predicting pressure sore risk dated 5/9/17 that documented Resident #10 was at moderate risk for developing a pressure injury.

A physician's order dated 1/20/17 documented, "Profor boots to BLE (bilateral lower extremities) as tolerated while in bed TID (three times a day)."

Resident #10's July 2017 TAR (treatment administration record) documented, "1/20/2017 Profor boots to BLE as tolerated while in bed

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1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

Resident #10 proffer boots were placed on resident by LPN on 7-19-17. Resident #10 does not have any skin breakdown.

2. How will the facility identify other residents having the potential to be affected by the same practice?

All other residents were identified by LPN unit manager on 8-2-17 for profor boots. 5 residents currently have profor boots all were in place upon audit.

3. What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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TID."

Resident #10's comprehensive care plan with an onset date of 1/4/16 documented, Risk for Pressure Ulcers. Resident is at risk for alteration in skin integrity Relating To: Braden Scale score; Impaired mobility; Incontinence; Nutritional status; History of skin impairments to coccyx (tailbone) and right heel...Provide treatments and creams per order..." Resident #10's CNA (certified nursing assistant) care directive dated 7/19/17 documented, "Profore boots to Both feet every shift while in bed..."

On 7/18/17 at 1:02 p.m. Resident #10 was lying in bed with a sheet covering her legs and feet. Protective boots were observed in a recliner.

On 7/19/17 at 8:45 a.m. Resident #10 was sitting up in bed with a sheet covering her legs and feet. Protective boots were observed in the resident's wheelchair.

On 7/19/17 at 9:08 a.m. a hospice CNA (certified nursing assistant) was observed entering Resident #10's room. Resident #10 remained in bed. The hospice CNA stated she was about to wash the resident. At this time, the hospice CNA was asked to remove the sheet from Resident #10's feet. The hospice CNA removed the sheet and the resident's legs were observed on a pillow; no protective boots were observed on Resident #10's feet. Protective boots were observed in the wheelchair.

On 7/19/17 at 9:10 a.m. an interview was conducted with CNA #1 (the CNA caring for Resident #10). CNA #1 was asked how she was made aware of the needed positioning devices or

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Staff development coordinator, Director of nursing and or unit managers will educate nursing staff by 8-14-17 on preventive skin care and the use of Profor boots to prevent skin breakdown.

Any license nurse who has not been educated by 8-14-17 will not be allowed to provide direct resident care until in-services are completed. All newly hired nurses will be educated during orientation.

Director of nursing and/or unit managers will audit placement of profor boots 5 times a week for 30 days and 3 times a week for 30 days, then 1 time a week for 30 days.

4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and do not reoccur?

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boots for each resident. CNA #1 stated usually the nurses tell her. When asked if each resident had a specific care card, CNA #1 stated she would have to find out. CNA #1 was asked if Resident #10 was supposed to have any special devices. CNA #1 stated the resident was supposed to have boots on her feet and a pillow positioned under her legs. CNA #1 was asked if she had checked to see if Resident #10 was wearing the boots. CNA #1 stated, "I was in there this morning. I didn't think to look. I'm so used to them being on."

On 7/19/17 at 1:20 p.m. an interview was conducted with LPN (licensed practical nurse) #2 (the nurse caring for Resident #10). LPN #2 was asked how she was made aware of the needed positioning devices or boots for each resident. LPN #2 stated the order was typically on the TAR and that information is passed on during report. When asked if Resident #10 required any devices, LPN #2 stated she needed to check the TAR.

On 7/19/17 at 2:50 p.m. an interview was conducted with LPN #3 (the unit manager). When asked the purpose of Resident #10's protective boots, LPN #3 stated the boots were used as a precaution to prevent skin breakdown to the resident's feet while she is in bed.

On 7/19/17 at 4:45 p.m. an interview was conducted with LPN #4. LPN #4 was asked what facility process was in place to ensure staff are following residents' care plans. LPN #4 stated, "We make sure education is in place first and foremost." LPN #4 stated staff could also reference residents' TARs. LPN #4 was asked if CNAs had any care guides they could follow.

The Director of nursing will present findings of audits for preventive skin interventions by use of profor boots to the quality assurance committee to review and make recommendations. Committee consist of Executive Director, Director of Nursing, Assist Director of Nursing, Social Services, Activities Director, Dietary Manager, Pharmacy consultant, Medical Director

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LPN #4 stated he would have to find out. On 7/19/17 at 4:55 p.m. LPN #4 stated CNAs can access care guides through the facility tablets.

On 7/19/17 at 5:20 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Care Planning and Interventions" documented, "The Care Plan addresses, to the extent possible...Interventions for preventing avoidable declines in functioning or functional levels..." The policy did not document specific information regarding following the care plan.

No further information was presented prior to exit.

(1) "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 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..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

F 309 SS=E — 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING — F 309

483.24 Quality of life
Quality of life is a fundamental principle that

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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 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
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 resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care in a manner to promote the highest level of well-being for five of 29 residents

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

Resident # 25 recent episode of hemorrhoids has resolved. Sitz baths have been discontinued on 8-3-17. New order written 7-22-17 for prn hemorrhoid crème.

Director of nursing reviewed resident #1 weights for the month of July on 8-1-17 with physician. MD notification was documented in the nurse's notes on 8-1-17. Physician will be notified of any 2# wt gain and documented on back of the treatment administration record.

Unit manager completed resident # 17 pain assessment on 8-1-17. Unit manager reviewed with physician current pain regimen on 8-2-17 and received orders for parameters to administer pain medication. Nurses will document non-pharmaceutical interventions on the pain flow sheet. When pain medications are administered the effectiveness of pain medication will be documented on pain flow sheet by license nurse giving the medications for 15 minutes, 30 minutes, 1 hour, and 3 hours.

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F 309	Continued From page 46	F 309	Unit manager completed resident # 11 pain assessment on 8-1-17. Unit manager reviewed with physician current pain regimen on 8-2-17 and received order for parameters to administer pain medication. Nurses will document non-pharmaceutical intervention on the pain flow sheet. When pain medication are administered the license nurse administering medication will document effectiveness on the pain flow sheet for 15 minutes, 30 minutes, 1 hour, and 3 hours.	

in the survey sample, Resident #25, #1, #17, #11 and #3.

1. The facility staff failed to provide sitz baths (a warm, shallow bath that cleanses the perineum, which is the space between the rectum and the vulva or scrotum) to Resident #25 as ordered by the physician.

2. The facility staff failed to notify the physician, of a weight gain of over two pounds in a day for Resident #1 as ordered per the physician orders.

3. The facility staff failed to assess Resident #17's pain prior to the administration of a PRN (as needed) pain medication and failed to assess and document the effectiveness of the medication after administration.

4.a. The facility staff failed to assess Resident #11's pain prior to and after administering as needed pain medications on multiple occasions during June and July 2017.

4.b. The facility staff failed to follow a physician's order to notify the physician of a weight gain of greater than two pounds in one day for Resident #11.

5.a. The facility staff failed to assess Resident #3's pain prior to and after administering as needed pain medications on multiple occasions in June and July 2017.

5.b. The facility staff failed to follow a physician's order to notify the physician of a resident's refusal of a weekly weight, and of a weight loss of greater than four pounds in one week for Resident #3.

Director of nursing on 8-1-17 reviewed with in house physician resident #11 weights for the month of July 2017. Notification was documented on 8-1-17 in nurse's notes by Direction of Nursing. No new orders were received. Will continue to obtain weight per orders and notify physician per orders and change in condition policy

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The findings include;

1. The facility staff failed to provide sitz baths (a warm, shallow bath that cleanses the perineum, which is the space between the rectum and the vulva or scrotum) to Resident #25 as ordered by the physician.

Resident #25 was admitted to the facility on 6/16/17 with diagnoses that included, but were not limited to; high blood pressure, diabetes, low blood pressure, chronic kidney disease, obesity and hemorrhoids.

Resident #25's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/13/17, coded Resident #25 as scoring a 14 out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #25 is cognitively intact. Resident #25 was also coded as requiring maximum assistance of one person for toileting.

A review of Resident #25's clinical record revealed, in part the following recommendation written by a general surgeon. "6/2/17 2. Hemorrhoids. Recommend Sitz baths daily." This recommendation was signed on 6/5/17 by the facility nurse practitioner, ASM (administrative staff member) #3.

A review of Resident #25's physician orders revealed that an order for sitz baths was not transcribed from the recommendation, as approved by the nurse practitioner.

Further review of Resident #25's clinical record revealed that Resident #25 was not receiving a

Unit manager completed resident #3 pain assessment on 8-1-17. Unit manager reviewed with physician current pain regimen on 8-2-17 and received orders for parameters to administer pain medication. Nurses will document non pharmaceutical interventions on pain flow sheet. When pain medication are administered the effectiveness of pain medications will be documented on pain flow sheet by licensed nurse giving the medication for 15 minutes, 30 minutes, 1 hours, and 3 hours.

Director of nursing on 8-1-17 reviewed with physician resident # 3 refusal of weight. Resident's weights for the month of July was reviewed with physician. Director of nursing documented physician notification of weights. Physician will be notified of weight loss per physician orders of greater than 2 # and documented on medication administration record.

2. How will the facility identify other residents having the potential to be affected by the same practice?

Unit manager reviewed on 8-2-17 all other residents requiring use of hemorrhoid crèmes. Only one other resident 13123 was identified to use hemorrhoid crème prn. Resident has not been dis-impacted.

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F 309	Continued From page 48	F 309	Unit manager reviewed all residents on 8-1-17 who were on prn medications for parameters and effectiveness of pain management. Unit manager reviewed with physician residents on prn mediations. Orders were received for parameters for medications. Unit manager wrote orders and placed on Medication administration record on 8-2-17.	

sitz bath daily as treatment for hemorrhoids.

A review of Resident #25's comprehensive care plan dated 6/16/17 did not reveal any documentation regarding relief of hemorrhoids through sitz bath treatments.

On 7/20/17 at 3:00 p.m. an interview was conducted with ASM #2, the director of nursing, and LPN (licensed practical nurse) #13, the floor nurse responsible for Resident #25's care. LPN #13 was asked to describe the process when a recommendation was received by an external provider. LPN #13 stated, "The recommendation goes to the provider either to (name of ASM #3, the nurse practitioner), or (name of ASM #5, the medical doctor). They have to sign off to say that they approve, they give the signed copy back to nursing and we (the nurses) transcribe the order." LPN #13 and ASM #2 both reviewed the recommendation from the general surgeon written on 6/2/17 and approved by ASM #3 on 6/5/17. LPN #13 was asked which orders should have been transcribed to the MAR. LPN #13 stated that the laxative and sitz baths should have been transcribed. LPN #13 and ASM #2 were asked to review the orders transcribed on 6/2/17. LPN #13 stated that the order for the sitz baths was not transcribed "I didn't think she could fit into the whirlpool bath up here. I asked the unit manager if we could recommend something different. That's where I left it; I don't know what happened after that." LPN #13 was asked if she followed up. LPN #13 stated that she didn't remember. LPN #13 was asked if Resident #13 had received any sitz baths for relief of her hemorrhoids. LPN #13 stated that she had not.

A policy was requested regarding following

3. What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.

Staff Development coordinator, Director of nursing and/or unit managers will educate license nurses by 8-14-17 on physician notification of change of condition per policy and physicians orders to include weight losses and weight gains.

Staff Development coordinator, director of nursing and/or unit managers will educate license nurses by 8-14-17 on assessing for pain and documenting non-pharmaceutical interventions on the pain flow sheet and when pain medication is given the nurse will document the effectiveness for 15 minutes,30 minutes, 1 hour, and 3 hours on pain flow sheet.

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F 309	Continued From page 49	F 309	Any license nurse that has not been in-serviced by 8-14-17 will not be allowed to provide direct resident care until in-services are completed. All newly hired licensed nurses will be educated during orientation. Director nursing and or unit managers will audit in grand rounds (am clinical meeting) residents with daily and weekly weights for physician notification and documentation on medication administration record 5 times a week for 30 days, then 3 times a week for 30 days, then 1 time a week for 30 days. Director of nursing and or unit managers will audit in grand rounds (am Clinical meeting) documentation of residents on prn pain medication for documentation of non-pharmaceutical interventions and if pain medications are given for documentation of effectiveness at 15 minutes, 30 minutes, 1 hour and 3 hours on pain flow sheet.	

physician orders.

A review of the facility document titled "Physician Orders" revealed, in part, the following documentation; "Policy: A physician must provide orders for the resident's immediate care. Procedure: Physician orders include the following; Special medical procedures required for the safety and well-being of the resident. Note: Medications, diets, therapy and any treatment may not be administered to the resident without a written order from the attending physician."

No further information was provided prior to the end of the survey process.

2. The facility staff failed to notify the physician, of a weight gain of over two pounds in a day for Resident #1 as ordered per the physician orders.

Resident #1 was admitted to the facility on 12/28/17 with a recent readmission on 5/30/17, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), severe peripheral artery disease (any abnormal condition affecting the arteries outside the heart (2)) above the knee amputation, atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)), cardiac disease, aneurysm (a saclike widening in a blood vessel (4)), gastrointestinal bleed and osteoarthritis (the most common form of arthritis occurring mostly in the elderly,

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characterized by degenerative changes in the joints (5)).

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 5/11/17, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating he was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living, except eating in which he required supervision of one staff member.

The physician order dated, 5/4/17 and when readmitted rewritten on 5/30/17, documented, "Daily weight, if gains 2 lbs. (pounds) or more in a day, notify MD/NP (medical doctor/nurse practitioner). Provide copy of weights to MD/NP weekly on Wednesday, daily."

The May 2017 TAR (treatment administration record) documented, "Daily weight, if gains 2 lbs. or more in a day, notify MD/NP. Provide copy of weights to MD/NP weekly on Wednesday, daily." The weights were documented as ordered daily. The weight documented on 5/4/17 - 125.3 (pounds). The weight documented on 5/5/17 - 129.3 lbs. A weight gain of four pounds. The weight documented on 5/14/17 - 127.9. The weight documented on 5/15/17 - 135.9, a weight gain of eight pounds. Review of the reverse side of the TAR did not evidence any documentation of notification to the physician per the physician order for a weight gain of greater than two pounds in one day.

Review of the nurse's notes for 5/5/17 and 5/15/17 failed to evidence any documentation of

4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and do not reoccur?

Director of nursing will report findings of audits of weight losses, weight gains and prn pain management intervention documentation to the quality assurance/ performance improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nursing, Assist Director of Nursing, Social Services, Activities Director, Dietary Manager, Pharmacy consultant, Medical Director

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notification of Resident #1's weight gains to the physician or nurse practitioner.

The June 2017 TAR documented, "Daily weight, if gains 2 lbs. or more in a day, notify MD/NP. Provide copy of weights to MD/NP weekly on Wednesday, daily." The weights were documented as ordered daily. The weight documented on 6/29/17 - 131.5 (pounds). The weight documented on 6/30/17 - 134.8; a weight gain of 3.3 lbs. Review of the reverse side of the MAR did not evidence any documentation of notification to the physician per the physician order for a weight gain of greater than two pounds in one day.

A review of the nurse's notes for 6/30/17 failed to evidence any documentation of notification to the physician or nurse practitioner for Resident #1's weight gain as documented above.

The comprehensive care plan dated, 12/28/16 and revised on 4/26/17, documented in part, "Problem: Resident is at risk for cardiac distress due to Dx (diagnosis) of CAD (coronary artery disease), HTN (high blood pressure) and A. Fib (atrial fibrillation)." The "Approaches" documented in part, "Monitor vital signs as indicated, notify MD/NP and family of significant change as needed, and weigh as per protocol."

An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/19/17 at 1:47 p.m. regarding physician orders for notification of a residents two pound weight gain in a day. LPN #3 stated, "We have to get the daily weight and then compare it with the previous day's weight and notify the doctor or NP if there is a weight gain of greater than two pounds and

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document it." When asked where the notification should be documented, LPN #3 stated, "It could be on the back of the TAR or in a nurse's note."

An interview was conducted with LPN #9 on 7/19/17 at 3:15 p.m. When asked why a physician would order daily weights and to be notified if there is a weight gain of two pounds or more in a day, LPN #9 stated, "We have to notify them because a weight gain could be related to fluid retention."

The facility policy, "Physician Orders" did not address following the physician orders.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

The executive director and the director of nursing were made aware of the above findings on 7/19/17 at 5:18 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 447.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55.
(4) Barron's Dictionary of Medical Terms for the

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Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 34.
(5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 422.

3. The facility staff failed to assess Resident #17's pain prior to the administration of a PRN (as needed) pain medication and failed to assess and document the effectiveness of the medication after administration.

Resident #17 was admitted to the facility on 6/15/13 with diagnoses that included but were not limited to: high blood pressure, abnormal posture, anemia, dementia, and osteoarthritis.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/15/17, coded Resident #17 as scoring a two on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of her activities of daily living.

A physician order dated, 2/22/17 documented, "Norco (used to treat moderate to moderately severe pain (1)) 5/325 mg (milligrams) take one tab (tablet) every 4 hours for pain PO (by mouth) PRN (as needed) daily."

The physician order dated, 5/1/17 documented, "Tylenol (used to treat pain or fever (2)) 325 mg (milligrams) tablet take 650 mg by mouth every 4 hours as needed for pain or fever > (greater than)

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100.7 PO PRN six times a day."

The April 2017 MAR (medication administration record) documented, "Tylenol 325 mg tablet take 650 mg by mouth every 4 hours as needed for pain or fever > 100.7 PO PRN six times a day." The Tylenol was documented as administered on 4/21/17 and 4/22/17. There was no documentation on the reverse side of the MAR.

Review of the "Pain Flow Sheet" dated, did not document anything related to the assessment of Resident #17's pain, administration of, or the effectiveness of the Tylenol administered on 4/21/17 and 4/22/17.

Review of the nurse's notes for 4/21/17 and 4/22/17, failed to evidence any documentation regarding the assessment of Resident #17's pain, administration of, or the effectiveness of the Tylenol administered to Resident #17.

The May 2017 MAR documented, "Norco 5/325 mg take one tab every 4 hours for pain PO PRN daily." The Norco was documented as administered on 5/4/17, 5/9/17 and 5/13/17. The reverse side of the MAR was blank.

Review of the "Pain Flow Sheet" did not document anything related to the assessment of Resident #17's pain, administration of, or the effectiveness of the Norco administered on 5/4/17, 5/9/17, and 5/13/17.

Review of the nurse's notes for 5/4/17, 5/9/17 and 5/13/17, failed to evidence any documentation regarding the assessment of, Resident #17's pain, administration of, or the effectiveness of the Norco administered.

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The May 2017 MAR documented, "Tylenol 325 mg tablet take 650 mg by mouth every 4 hours as needed for pain or fever > 100.7 PO PRN six times a day." The Tylenol was documented as administered on 5/3/17, 5/13/17 and 5/16/17. There was no documentation on the reverse side of the MAR.

Review of the "Pain Flow Sheet" did not document anything related to the assessment of Resident #17's pain, administration of, or the effectiveness of the Tylenol administered on 5/3/17, 5/13/17 and 5/16/17.

Review of the nurse's notes for 5/3/17, 5/13/17 and 5/16/17 failed to evidence any documentation regarding the assessment of Resident #17's pain, administration of, or the effectiveness of the Tylenol administered.

The June 2017 MAR documented, "Tylenol 325 mg tablet take 650 mg by mouth every 4 hours as needed for pain or fever > 100.7 PO PRN six times a day." The Tylenol was documented as administered on 612/17, 6/15/17, 6/19/17 and 6/23/17. There was no documentation on the reverse side of the MAR.

Review of the "Pain Flow Sheet" did not document anything related to the assessment of Resident #17's pain, administration of, or the effectiveness of the Tylenol administered on 612/17, 6/15/17, 6/19/17 and 6/23/17.

Review of the nurse's notes for 612/17, 6/15/17, 6/19/17 and 6/23/17 failed to evidence any documentation regarding the assessment of Resident #17's pain, administration of, or the

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effectiveness of the Tylenol administered.

The July 2017 MAR documented, "Tylenol 325 mg tablet take 650 mg by mouth every 4 hours as needed for pain or fever > 100.7 PO PRN six times a day." The Tylenol was documented as administered on 7/8/17. There was no documentation on the reverse side of the MAR.

Review of the "Pain Flow Sheet" did not document anything related to the assessment of Resident #17's pain, administration of, or the effectiveness of the Tylenol administered on 7/8/17.

Review of the nurse's notes for 7/8/17 failed to evidence any documentation regarding the assessment of Resident #17's pain, administration of, or the effectiveness of the Tylenol administered.

The comprehensive care plan dated, 12/31/14 with a target date of 9/29/17, documented in part, "Problems: Resident is at risk for pain related to Dx (diagnosis) of arthritis, generalized discomforts." The "Approaches" documented in part, "Administer/observe for effectiveness and for possible side effects from PRN pain medication. Notify the resident's physician if they do not state/demonstrate relief or reduction of pain after one hour of receiving the first intervention."

An interview was conducted with LPN (licensed practical nurse) #8 on 7/20/17 at 12:22 p.m. regarding the process for administering a PRN medication for pain. LPN #8 stated, "First you assess the resident's complaint of pain. Then you administer the pain medication and then go

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back and see if it was effective." When asked where this is documented, LPN #8 stated, "We use the pain flow sheet or you could document it in the nurse's notes."

An interview was conducted with LPN #4 on 7/20/17 at 12:28 p.m., regarding the process followed for a resident complaint of pain. LPN #4 stated, "You assess the resident's pain for location, pain scale and intensity. Then you check the PRN medication list and administer medication. After about an hour or so you should go back and check to see if the medication was effective." When asked where this is documented, LPN #4 stated, "On the back of the MAR and pain flow sheet."

The executive director, ASM (administrative staff member) #1 and ASM #2, the director of nursing were made aware of the above findings on 7/20/17 at 4:05 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=aaef2d01-126d-4aab-9b2a-eee31a769150
(2) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=59282

4.a. The facility staff failed to assess Resident #11's pain prior to and after administering as needed pain medications on multiple occasions during June and July 2017.

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Resident #11 was admitted to the facility on 3/25/15 and most recently readmitted on 5/1/17 with diagnoses including, but not limited to: heart failure, high blood pressure, diabetes, and amputation of his left leg below the knee. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 5/8/17, he was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as having pain during the look back period.

A review of Resident #11's clinical record revealed, in part, the following order dated 5/1/17, and most recently signed by the physician on 7/3/17: "Oxycodone (used to relieve moderate to severe pain (1)) 5 mg (milligram) tablet. Take 1 tab (tablet) PO (by mouth) q 4 hrs (every four hours) PRN (as needed) for pain PO PRN daily."

A review of the MARs (medication administration records) and pain flow sheets for Resident #11 revealed that in June 2017, on eight of 24 days when Resident #11 received the prn dose of Oxycodone, the facility staff failed to document evidence of the location of Resident #11's pain, the severity of the resident's pain, and the effectiveness of the Oxycodone on the resident's pain. These dates were: 6/8/17, 6/10/17, 6/16/17, 6/21/17, 6/24/17, 6/25/17, 6/28/17, and 6/30/17. Further review of the MARs and pain flow sheets revealed that in July 2017, on three of 13 days when Resident #11 received the prn dose of Oxycodone, the facility staff failed to document evidence of the location of Resident #11's pain, the severity of the resident's pain, and the effectiveness of the Oxycodone on the

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resident's pain. These dates were: 7/3/17, 7/6/17, and 7/9/17.

A review of Resident #11's comprehensive care plan dated 7/27/16 and updated on 5/1/17 revealed, in part, the following: "Administer/observe for effectiveness and for possible side effects from pain medication, PRN pain medication, (see MAR)."

On 7/19/17 at 8:25 a.m., Resident #11 was interviewed regarding his pain medications. When asked if the facility staff regularly asked him the location of his pain, asked him to rate his pain severity, and returned to assess the effectiveness of the pain medication he had received, he stated: "No. They hardly ever do that."

On 7/20/17 at 8:30 a.m., LPN (licensed practical nurse) #4, a unit manager, was interviewed. When asked what nurses should do prior to and after giving a prn pain medicine, LPN #4 stated: "They should assess the pain." He stated this assessment should include the location, rate, and effectiveness of the pain medication. When asked where this information should be documented, LPN #4 stated: "If it's done, it should be signed on the front of the MAR, and the assessment should go either on the back of the MAR or the pain flow sheet." When asked to review the above referenced MARs and pain flow sheets for Resident #11, LPN #4 stated: "It looks like it wasn't always done. If it's not documented, it's not done." He stated that he and the other unit manager are responsible for auditing the MARs and TARs.

On 7/20/17 at 9:50 a.m., LPN #6 was interviewed.

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She stated a resident's pain should always be assessed and documented prior to and after the administration of an as-needed pain medication. She stated the assessment and documentation should include the date, reason, and effectiveness of a pain medication. She stated the assessment should be documented on either the back of the MAR or the pain flow sheet. When shown the above referenced MARs and pain flow sheets for Resident #11, LPN #6 stated: "Yeah. It would be hard to say the assessments were done since they are not documented."

On 7/10/17 at 10:10 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. Policies regarding resident assessment for prn pain medications were requested.

On 7/20/17 at 1:50 p.m., LPN #3 was interviewed. She stated residents should be assessed for the location and severity of pain before a prn medication is administered. She stated the nurse should follow up to see if a medication has been effective for pain. She stated these assessments should be documented on the back of the MAR and/or on the resident's pain flow sheet.

A review of the facility policy "Administration of Medication" revealed, in part, the following: "All medications are administered safely and appropriately to help residents overcome illness, relieve/prevent symptoms, and help in diagnosis...PRN medication is charted with initials, and time is given in the corner of the box [on the MAR]. The following situations require an accompanying note...pain."

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No further information was provided prior to exit.

(1) "Oxycodone is used to relieve moderate to severe pain. Oxycodone extended-release tablets and extended-release capsules are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682132.html.

Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Nurses need to approach pain management systematically to understand a client's pain and to provide appropriate intervention....it is necessary to monitor pain on a consistent basis....Assessment of common characteristics of pain helps the nurse form an understanding of the type of pain, its pattern, and types of interventions that may bring relief....Onset and duration....Location....Intensity....Quality....Pain Pattern....Relief Measures....Contributing Symptoms....Pain therapy requires an individualized approach....Nurses administer and monitor interventions ordered by physicians for pain relief and independently use pain-relief measures that complement those prescribed by a physician....Effective communication of a client's assessment of pain and his or her response to intervention is facilitated by accurate and thorough documentation. This communication needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The

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client is not responsible for ensuring that this information is accurately transmitted. A variety of tools such as a pain flow sheet or diary will help centralize the information about pain management."

4.b. The facility staff failed to follow a physician's order to notify the physician of a weight gain of greater than two pounds in one day for Resident #11.

A review of the physician's orders for Resident #11 revealed, in part, the following order dated 5/1/17, and most recently signed by the physician on 7/3/17: "Daily weight. If gains 2 lbs (pounds) or more in a day notify MD/NP (doctor/nurse practitioner). Provide copy of weights to MD/NP weekly on Wednesday."

A review of the daily weights for Resident #11 revealed, in part, the following:
- 6/2/17 - 235.9; 6/3/17 - 240.7
- 6/8/17 - 232.9; 6/9/17 - 235
- 6/11/17 - 233.8; 6/12/17 - 237.7
- 6/25/17 - 237.4; 6/26/17 - 242.3
-6/28/17 - 243.1; 6/29/17 - 245.8

Further review of Resident #11's clinical record, including the back of the TARs (treatment administration records) and nurses' notes, failed to reveal evidence that the facility staff notified the physician or NP of the weight gains on the above referenced dates.

A review of the comprehensive care plan for Resident #11 dated 7/27/16 and updated 11/17/16 revealed, in part, the following: "Daily weights...prior to getting out of bed."

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On 7/20/17 at 9:10 a.m., LPN (licensed practical nurse) #3, a unit manager was interviewed. When asked if she knew why Resident #11 had a physician's order for daily weights, LPN #3 stated: "He will start increasing really fast. He has heart failure." When asked who is responsible for reporting a daily weight gain of greater than two pounds to the physician or NP, LPN #3 stated: "The floor nurse is responsible."

On 7/20/17 at 9:50 a.m. at 9:50 a.m., LPN #6 was interviewed. She stated the aides are responsible for obtaining the daily weights and writing the weights on the residents' ADL (activities of daily living) sheets. She stated the floor nurse is responsible for checking the resident's weight against the previous weights and to notify the physician or NP if applicable. She stated the notification of the physician should be documented either on the back of the TAR or in the nurses' notes. When asked to review the TARs and nurses' notes for Resident #11 regarding the daily weights, LPN #6 stated: "No. It doesn't look like anyone was notified on those dates."

On 7/20/17 at 10:00 a.m. LPN #3, a unit manager, was interviewed. LPN #3 stated: "There is no evidence of the physician being notified on the dates you pointed out."

On 7/10/17 at 10:10 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. Policies regarding resident assessment for daily weights/following physician's orders were requested.

A review of the facility policy "Physician Orders"

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failed to reveal information related to the facility staff's responsibility to follow physicians' orders.

In Fundamentals of Nursing, 6th edition, 2005, Patricia A. Potter and Anne Griffin Perry; Mosby, Inc., Page 419: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

5.a. The facility staff failed to assess Resident #3's pain prior to and after administering as needed pain medications on multiple occasions in June and July 2017.

Resident #3 was admitted to the facility on 2/23/17 and most recently readmitted on 6/1/17 with diagnoses including, but not limited to: history of bladder and kidney cancer, heart attack and right above the knee amputation. On the most recent MDS (minimum data set), a 14 day Medicare assessment with an assessment reference date of 6/15/17, Resident #3 was coded as having no cognitive impairment for making daily decisions. He was coded as having received pain medications during the look back period.

A review of the physician's orders for Resident #3 revealed the following orders written 6/1/17 and signed by the physician on 6/26/17: "Hydrocodone-acetaminophen (Vicodin (1)) 5-325 mg (milligrams). Take 1 tablet po q 4 hours prn (by mouth every 4 hours as needed) pain...Tylenol 325 mg tablet. Take 2 Tabs (tablets) po q 6 hrs prn for pain or fever."

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A review of the MARs and pain flow sheets for Resident #3 revealed that on the following dates, Resident #3 received prn Vicodin without any documented assessment of his pain or the effectiveness of the medication: 6/3/17, 6/15/17; 6/16/17, 6/23/17, 6/27/17, 7/15/17 and 7/16/17.

A review of the MARs and pain flow sheets for Resident #3 revealed that on the following dates, Resident #3 received prn Tylenol without any documented assessment of his pain or the effectiveness of the medication: 6/5/17 and 6/12/17.

A review of Resident #3's comprehensive care plan dated 6/1/17 revealed, in part, the following: "Administer/observe for effectiveness and for possible side effects from pain medication, PRN pain medication, (see MAR)."

On 7/20/17 at 8:30 a.m., LPN (licensed practical nurse) #4, a unit manager, was interviewed. When asked what nurses should do prior to and after giving a prn pain medicine, LPN #4 stated: "They should assess the pain." He stated this assessment should include the location, rate, and effectiveness of the pain medication. When asked where this information should be documented, LPN #4 stated: "If it's done, it should be signed on the front of the MAR, and the assessment should go either on the back of the MAR or the pain flow sheet." When asked to review the above referenced MARs and pain flow sheets for Resident #3, he stated: "It looks like it wasn't always done. If it's not documented, it's not done." He stated that he and the other unit manager are responsible for auditing the MARs and TARs.

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On 7/20/17 at 9:50 a.m., LPN #6 was interviewed. She stated a resident's pain should always be assessed and documented prior to and after the administration of an as-needed pain medication. She stated the assessment and documentation should include the date, reason, and effectiveness of a pain medication. She stated the assessment should be documented on either the back of the MAR or the pain flow sheet. When shown the above referenced MARs and pain flow sheets for Resident #3, LPN #6 stated: "Yeah. It would be hard to say the assessments were done since they are not documented."

On 7/19/17 at 5:20 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

(1) "Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. Hydrocodone relieves cough by decreasing activity in the part of the brain that causes coughing." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601006.html.

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LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

(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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5.b. The facility staff failed to follow a physician's order to notify the physician of a resident's refusal of a weekly weight, and of a weight loss of greater than four pounds in one week for Resident #3.

A review of Resident #3's clinical record revealed the following physician's order dated 6/1/17 and signed by the physician on 6/26/17: "Weekly weight on Mondays. Notify MD/NP (medical doctor/nurse practitioner) of wt (weight) 4 lb (pounds) or greater in a week. Weekly."

A review of Resident #3's weekly weights revealed, in part, the following:
- 6/12/17 - 124
- 6/19/17 - 116
- 6/26/17 - Refused

Further review of Resident #3's clinical record, including the back of the TARs (treatment administration records) and nurses' notes, failed to reveal evidence that the facility staff notified the physician or NP of Resident #3's weight loss and refusal to be weighed on the above referenced dates.

A review of Resident #3's comprehensive care plan dated 6/1/17 revealed, in part, the following: "Weigh and observe results."

On 7/20/17 at 8:15 a.m., LPN (licensed practical nurse) #4, a unit manager, was interviewed. When asked if he knew why Resident #3 had a physician's order for weekly weights, LPN #4 stated: "Weekly weights are part of the NAR (nutritionally at risk). It was because of the possibility of weight loss." When asked who

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monitors residents' weekly weights, he stated that he, the dietary manger, the other unit manager, and at least one speech therapists meet weekly to discuss residents who are at risk of nutritional compromise and weight loss. When asked who is responsible for following the physician's order to notify the physician of a weight loss of greater than four pounds in a week, LPN #4 stated: "The unit managers are responsible. I was responsible." When asked if a physician should be notified if a resident with an order for weekly weights refuses to be weighed, LPN #4 stated: "Absolutely." LPN #4 was asked to check to see if he could locate evidence that the physician was notified of the above instances of weight loss and refusal to be weighed. LPN #4 returned to the surveyor at 9:10 a.m. and stated: "I could not find any evidence of the notification. It should have been done."

On 7/20/17 at 10:00 a.m. LPN #3, a unit manager, was interviewed. She stated: "There is no evidence of the physician being notified on the dates you pointed out."

On 7/20/17 at 10:10 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns.

No further information was presented prior to exit.

F 314 SS=D 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES — F 314

(b) Skin Integrity -

(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the

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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:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services to prevent the development of pressure injury for one of 29 residents in the survey sample, Resident #10.

The facility staff failed to apply Resident #10's physician prescribed protective boots.

The findings include:

Resident #10 was admitted to the facility on 1/4/16. Resident #10's diagnoses included but were not limited to: chronic kidney disease, high blood pressure and a history of a pressure ulcer of the right hip. Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/27/17, coded the resident's cognition as severely impaired. Section M documented Resident #10 was at risk of developing pressure injuries (1) but did not have any.

F-314

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

Resident #10 proffer boots were placed on resident by LPN on 7-19-17. Resident #10 does not have any skin breakdown.

2. How will the facility identify other residents having the potential to be affected by the same practice?

All other residents were identified by LPN unit manager on 8-2-17 for Profor boots. 5 residents currently have profor boots all were in place upon audit.

3. What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.

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Review of Resident #10's clinical record revealed a Braden scale for predicting pressure sore risk dated 5/9/17 that documented Resident #10 was at moderate risk for developing a pressure injury.

A physician's order dated 1/20/17 documented, "Profor boots to BLE (bilateral lower extremities) as tolerated while in bed TID (three times a day)."

Resident #10's July 2017 TAR (treatment administration record) documented, "1/20/2017 Profor boots to BLE as tolerated while in bed TID."

Resident #10's comprehensive care plan with an onset date of 1/4/16 documented, Risk for Pressure Ulcers. Resident is at risk for alteration in skin integrity Relating To: Braden Scale score; Impaired mobility; Incontinence; Nutritional status; History of skin impairments to coccyx (tailbone) and right heel...Provide treatments and creams per order..." Resident #10's CNA (certified nursing assistant) care directive dated 7/19/17 documented, "Profore boots to Both feet every shift while in bed..."

On 7/18/17 at 1:02 p.m. Resident #10 was lying in bed with a sheet covering her legs and feet. Protective boots were observed in a recliner.

On 7/19/17 at 8:45 a.m. Resident #10 was sitting up in bed with a sheet covering her legs and feet. Protective boots were observed in the resident's wheelchair.

On 7/19/17 at 9:08 a.m. a hospice CNA (certified nursing assistant) was observed entering Resident #10's room. Resident #10 remained in bed. The hospice CNA stated she was about to

Staff development coordinator, Director of nursing and or unit managers will educate nursing staff by 8-14-17 on preventive skin care and the use of Profor boots to prevent skin breakdown.

Any license nurse who has not been educated by 8-14-17 will not be allowed to provide direct resident care until in-services are completed. All newly hired nurses will be educated during orientation.

4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and do not reoccur?

The Director of nursing will present findings of audits for preventive skin interventions by use of profor boots to the quality assurance committee to review and make recommendations. Committee consist of Executive Director, Director of Nursing, Assist Director of Nursing, Social Services, Activities Director, Dietary Manager, Pharmacy consultant, Medical Director

08/23/17

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wash the resident. At this time, the hospice CNA was asked to remove the sheet from Resident #10's feet. The hospice CNA removed the sheet and the resident's legs were observed on a pillow; no protective boots were observed on Resident #10's feet. Protective boots were observed in the wheelchair.

On 7/19/17 at 9:10 a.m. an interview was conducted with CNA #1 (the CNA caring for Resident #10). CNA #1 was asked how she was made aware of the needed positioning devices or boots for each resident. CNA #1 stated usually the nurses tell her. When asked if each resident had a specific care card, CNA #1 stated she would have to find out. CNA #1 was asked if Resident #10 was supposed to have any special devices. CNA #1 stated the resident was supposed to have boots on her feet and a pillow positioned under her legs. CNA #1 was asked if she had checked to see if Resident #10 was wearing the boots. CNA #1 stated, "I was in there this morning. I didn't think to look. I'm so used to them being on."

On 7/19/17 at 1:20 p.m. an interview was conducted with LPN (licensed practical nurse) #2 (the nurse caring for Resident #10). LPN #2 was asked how she was made aware of the needed positioning devices or boots for each resident. LPN #2 stated the order was typically on the TAR and that information is passed on during report. When asked if Resident #10 required any devices and LPN #2 stated she needed to check the TAR.

On 7/19/17 at 2:50 p.m. an interview was conducted with LPN #3 (the unit manager). When asked the purpose of Resident #10's protective boots, LPN #3 stated the boots were

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used as a precaution to prevent skin breakdown to the resident's feet while she is in bed.

On 7/19/17 at 5:20 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Pressure Ulcer Prevention" documented, "5. Measures to protect the patient against the adverse effects of external mechanical forces, such as pressure, friction, and shear are implemented in the plan of care...d) heel protection/suspension should be implemented while the patient is in bed..."

No further information was presented prior to exit.

(1) "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 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..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

F 314

F 315 SS=D 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER

F 315

(e) Incontinence.
(1) The facility must ensure that resident who is continent of bladder and bowel on admission

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receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-

(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
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 maintain a Foley catheter in a sanitary manner for one of 29 residents in the survey sample,

F-315

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

Licensed nurse adjusted resident # 18 Foley catheter on 7-20-17 so that it was not touching the floor. Resident # 18 has not had a urinary infection or treatment for past 30 days.

2. How will the facility identify other residents having the potential to be affected by the same practice?

Unit manager completed audit of all resident with Foley catheters on 8-2-17. No Foley catheters tubing or bag was found on floor.

3. What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.

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Resident #18.

The facility staff failed to prevent Resident #18's Foley catheter (soft, plastic or rubber tube that is inserted into the bladder to drain the urine (1)) collection bag from touching the floor on 7/20/17.

The findings include:

Resident #18 was admitted to the facility on 5/7/16 and most recently readmitted on 6/29/16 with diagnoses including, but not limited to: history of a stoke with right side paralysis, high blood pressure, depression, and difficulty swallowing. On the most recent MDS (minimum data set), an annual assessment with an assessment reference date of 5/11/17, Resident #3 was coded as having both short term and long term memory loss, and as being severely cognitively impaired for making daily decisions. He was not coded as having a Foley catheter during the look back period.

On 7/20/17 at 12:00 p.m. and 1:30 p.m., Resident #18 was observed lying in bed with his eyes closed. Foley catheter tubing attached to a collection bag was visible from the hallway. The Foley catheter urinary collection bag was observed lying partially on the floor.

A review of the physician's orders for Resident #18 revealed the following order, written on 6/17/17 and most recently signed by the physician on 7/6/17: "Insert Foley catheter 16 F (French)/10 ml (milliliter) balloon."

A review of Resident #18's comprehensive care [illegible] dated 5/19/16 and updated 6/17/17 revealed, [illegible], the following: "Foley cath (catheter) care

Staff development coordinator, director of nursing and/or unit managers will educate all nursing staff on infection control process by 8-14-17. Education will include tubing and bag not to be placed on or touching the floor. Any nursing staff that have not completed in-service will not be allowed to provide direct resident care until in-services are completed.

All newly hired nursing staff will be educated in orientation.

Director of nursing and /or unit managers will audit placement of Foley catheter tubing and catheter bags 5 times a week for 30 days, then 3 times a week for 30 days and 1 time a week for 30 days.

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q (every) shift as ordered."

On 7/20/17 at 1:40 p.m., LPN (licensed practical nurse) #6 and CNA (certified nursing assistant) #8 accompanied this surveyor to Resident #18's bedside. When asked if they observed anything concerning, LPN #6 stated: "Yes. The catheter bag should not be on the floor." When asked why that is concerning, LPN #6 stated: "Infection control." CNA #8 stated: "Germs can get into the bag if it is dragging the floor like that."

On 7/20/17 at 4:10 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #4, the nurse consultant, were informed of these concerns.

A review of the facility policy "Foley Catheter Drainage" revealed, in part, the following: "Attach the drainage bag to the frame of the bed. Secure the drainage tube to the bedding by using a clamp. NOTE: Keep the drainage bag off the floor."

No further information was provided prior to exit.

(1) "Foley catheter - a soft, plastic or rubber tube that is inserted into the bladder to drain the urine." This information is taken from the website http://www.nlm.nih.gov/medlineplus/ency/article/003981.htm.

According to Fundamentals of Nursing Lippincott Williams and Wilkins Eighth Edition 2006, Lippincott Company, page 757, titled Renal and Urinary Disorders, under the heading "Management of a Patient with an Indwelling Catheter and Closed Drainage System" the subheading: "Maintaining a closed drainage

4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and do not reoccur?

Director of nursing will report finding of audits on Foley catheters to the quality assurance/performance improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nursing, Assist Director of Nursing, Social Services, Activities Director, Dietary Manager, Pharmacy consultant, Medical Director

08/25/17

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F 315	Continued From page 76 system: 2. Maintain an unobstructed urine flow. b. Urine should not be allowed to collect in tubing because free flow of urine must be maintained to prevent urinary tract infection. Improper drainage occurs when the tubing is kinked or twisted, allowing pools of urine to collect in the tubing. c. Keep the bag off the floor to prevent bacterial contamination."	F 315		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic	F 328	F-328 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? License nurse adjusted resident #1 oxygen to prescribed rate of 3 liters per minute on 7-20-17. License nurse will check O2 setting each shift and document on medication administration sheet. License nurse adjusted resident # 16 oxygen to prescribed rate of 2 liters per minute on 7-20-17. License nurse will check O2 setting each shift and document on medication administration sheet Licensed nurse adjusted resident #8 oxygen to prescribed rate of 2 liters per minute on 7-20-17. License nurse will check O2 setting each shift and document on medication administration sheet.	

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

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abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
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 administer oxygen per the physician order for three of 29 residents in the survey sample, Residents #1, #16 and #8.

1. The facility staff failed to administer oxygen to Resident #1 at the physician prescribed rate of three liters.

2. How will the facility identify other residents having the potential to be affected by the same practice?
Unit managers audited all residents on 8-1-17 who are receiving oxygen for appropriate administration of oxygen.

3. What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.
Staff Development coordinator, Director of nursing and/or unit mangers will educate all nursing staff on appropriate administration of oxygen by 8-14-17.

Director of nursing and/or unit managers will audit oxygen for appropriate administration per physician orders 5 times a week for 30 days, then 3 times a week for 30 days, then 1 time a week for 30 days.

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2. The facility staff failed to administer oxygen to Resident #16 at the physician prescribed rate of two liters.

3. The facility staff failed to administer oxygen to Resident #8 per the physician prescribed rate of two liters.

The findings include:

1. Resident #1 was admitted to the facility on 12/28/17 with a recent readmission on 5/30/17, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), severe peripheral artery disease (any abnormal condition affecting the arteries outside the heart (2)), above the knee amputation, atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)), cardiac disease, aneurysm (a saclike widening in a blood vessel (4)), gastrointestinal bleed and osteoarthritis (the most common form of arthritis occurring mostly in the elderly, characterized by degenerative changes in the joints (5)).

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 5/11/17, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating he was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of

Any license nurses who have not completed education by 8-14-17 will not be allowed to provide direct resident care until in-services are completed.
All newly hired nurses will be educated in orientation.

4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and do not reoccur?

Director of nursing will report finding monthly of oxygen audits for appropriate settings to the quality assurance/performance improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nursing, Assist Director of Nursing, Social Services, Activities Director, Dietary Manager, Pharmacy consultant, Medical Director

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his activities of daily living, except eating in which he required supervision of one staff member. In Section O - Special Treatments, Procedures, and Programs" the resident was coded as using oxygen during the look back period.

Observation was made of Resident #1 on 7/18/17 at 1:20 p.m. The resident was in bed with his oxygen on via a nasal cannula (a plastic tube with prongs that rest just inside the nose) connected to an oxygen concentrator. The oxygen concentrator was observed with the flowmeter ball sitting between the 3.0 and 3.5 L/Min (liters per minute) rate. Resident #1 was again observed on 7/19/17 at 7:38 a.m., 9:55 a.m. and 1:34 p.m., during each observation the flow rate was set with the ball between the 3.0 and 3.5 L/Min flow rate. On 7/20/17 at 8:28 a.m. Resident #1 was observed in bed with his oxygen in place. The concentrator was set with the flowmeter ball between the 3.0 and 3.5 L/Min flow rate. This observation was confirmed by another surveyor.

On 7/20/17 at 1:14 p.m. LPN (licensed practical nurse) #14 was asked to come to Resident #1's room. The oxygen was on the resident. LPN #14 was asked to verify the oxygen flow rate, LPN #3 stated, "It's set between 3 and 3.5 (liters per minute)." When asked what oxygen flow rate Resident #1 was prescribed, LPN #14 stated, "Three liters." When asked how often a nurse is to check the oxygen concentrator for the physician ordered rate, LPN #14 stated, "It should be checked at least once a shift."

An interview was conducted with LPN #3, the unit manager, on 7/20/17 at 1:16 p.m. When asked how an oxygen concentrator should be read, LPN #3 stated, "You have to get at eye level and you

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his activities of daily living, except eating in which he required supervision of one staff member. In Section O - Special Treatments, Procedures, and Programs" the resident was coded as using oxygen during the look back period.

Observation was made of Resident #1 on 7/18/17 at 1:20 p.m. The resident was in bed with his oxygen on via a nasal cannula (a plastic tube with prongs that rest just inside the nose) connected to an oxygen concentrator. The oxygen concentrator was observed with the flowmeter ball sitting between the 3.0 and 3.5 L/Min (liters per minute) rate. Resident #1 was again observed on 7/19/17 at 7:38 a.m., 9:55 a.m. and 1:34 p.m., during each observation the flow rate was set with the ball between the 3.0 and 3.5 L/Min flow rate. On 7/20/17 at 8:28 a.m. Resident #1 was observed in bed with his oxygen in place. The concentrator was set with the flowmeter ball between the 3.0 and 3.5 L/Min flow rate. This observation was confirmed by another surveyor.

On 7/20/17 at 1:14 p.m. LPN (licensed practical nurse) #14 was asked to come to Resident #1's room. The oxygen was on the resident. LPN #14 was asked to verify the oxygen flow rate, LPN #3 stated, "It's set between 3 and 3.5 (liters per minute)." When asked what oxygen flow rate Resident #1 was prescribed, LPN #14 stated, "Three liters." When asked how often a nurse is to check the oxygen concentrator for the physician ordered rate, LPN #14 stated, "It should be checked at least once a shift."

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want the line in the middle of the ball."

The physician order dated, 5/30/17 documented in part, "O2 (oxygen) 3 L (liters) nc (nasal cannula) continuously TID (three times a day)."

The MAR (medication administration record) for July 2017 documented, "O2 3 L nc continuously TID." It was signed off as being administered as ordered on all three shifts for the month of July.

Review of the comprehensive care plan did not reveal any documentation of oxygen on the care plan.

The facility policy, "Oxygen Use, General" documented in part, "1. Oxygen therapy is administered to the resident only upon the written order of a licensed physician." There was no documentation related to setting the rate.

The manufacturer's instruction manual for the oxygen concentrators documented in part, "To properly read the flowmeter, locate the prescribed flow rate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/Min (liters per minute) line prescribed."

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen

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administration."

The executive director, ASM (administrative staff member) #1 and the director of nursing, ASM #2 were made aware of the above findings on 7/20/17 at 4:05 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 447.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 34.
(5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 422.

2. The facility staff failed to administer oxygen to Resident #16 at the physician prescribed rate of two liters.

Resident #16 was admitted to the facility on 4/2/14 with a most recent readmission on 12/7/16 with diagnoses that included but were not limited to: high blood pressure, shortness of breath, edema, pain, history of respiratory failure, anemia, chronic kidney disease and obesity.

The most recent MDS (minimum data set)

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assessment, a quarterly assessment with an assessment reference date of 6/15/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen during the look back period.

Observation was made of Resident #16 on 7/20/17 at 12:05 p.m. She was up in her wheelchair with her oxygen on via a nasal cannula (a plastic tube with prongs that rest just inside the nose) connected to an oxygen concentrator set at 1.5 liters per minute. The center of the flowmeter ball was on the line for 1.5 liters per minute. This observation was verified by another surveyor. The resident was again observed on 7/20/17 at 12:45 p.m., the oxygen was set at 1.5 liters.

On 7/20/17 at 1:20 p.m. LPN (licensed practical nurse) #3 was asked to come to the resident's room. The oxygen was on the resident. LPN #3 was asked to verify what flow rate the oxygen was set at, LPN #3 stated, "It's set at 1.5 (liters per minute)." When asked what oxygen flow rate Resident #16 was prescribed, LPN #3 stated she wanted to check the physician orders before answering the question. LPN #3 went to the nurse's station and reviewed the physician orders for Resident #16. LPN #3 stated, "She's supposed to be on 2 liters (per minute)." When asked how often the nurse is to check the flow

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rate of residents' oxygen, LPN #3 stated, "At least once a shift and they have to sign it off on the MAR (medication administration record)."

On 7/20/17 at 1:23 p.m. an interview was conducted with LPN #7. When asked how often a nurse should check the flow rate of a resident's oxygen, LPN #7 stated, "Should check it each time you go in there and a minimum of once a shift." When asked if she had checked Resident #16's oxygen flow rate this shift, LPN #7 stated, "I have not."

The physician order dated, 12/7/16, signed by the physician on 7/3/17 documented, "Oxygen at 2 L (liters) via NC (nasal cannula) as needed for SOB (shortness of breath)/comfort TID (three times a day)."

The comprehensive care plan dated, 1/8/15, with a target date of 9/28/17, documented in part, "Problems: Resident is at risk for alteration in respiratory status relating to Dx (diagnosis) of CHF (congestive heart failure) and restrictive lung disease." The "Approaches" documented in part, "Place O2 (oxygen) per order."

The executive director, ASM (administrative staff member) #1 and the director of nursing, ASM #2 were made aware of the above findings on 7/20/17 at 4:05 p.m.

No further information was provided prior to exit.
3. The facility staff failed to administer oxygen to Resident #8 per the physician prescribed rate of two liters.

Resident #8 was admitted to the facility on 7/6/17. Resident #8's diagnoses included but were not

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limited to: diabetes, congestive heart failure and a diabetic foot ulcer. Resident #8's admission MDS (minimum data set) was not complete. An initial data collection tool dated 7/6/17 documented Resident #8 was alert and oriented. The tool further documented the resident was on room air (not receiving oxygen).

Review of Resident #8's clinical record revealed standing orders signed by the physician on 7/6/17. The standing orders documented, "Oxygen Orders: O2 (oxygen) at 2 Liters via nasal cannula or facemask PRN (as needed) for O2 saturation less than 90% or signs/symptoms of respiratory distress and call MD (medical doctor)/NP (nurse practitioner)..."

Resident #8's July 2017 MAR (medication administration record) and TAR (treatment administration record) failed to document information regarding oxygen. Resident #8's interim care plan initiated on 7/6/17 failed to document information regarding oxygen. The resident's comprehensive care plan was not complete.

On 7/18/17 at 1:04 p.m., 7/18/17 at 4:55 p.m., 7/19/17 at 8:50 a.m. and 7/19/17 at 11:15 a.m. Resident #8 was observed in bed receiving oxygen via nasal cannula connected to an oxygen concentrator. The flowmeter on the oxygen concentrator was set between one and a half liters and two liters as evidenced by the bottom of the ball in the flowmeter on the one and a half liter line and the top of the ball on the two liter line.

On 7/20/17 at 8:32 a.m. Resident #8 was sitting up in bed and was not receiving oxygen.

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On 7/20/17 at 1:25 p.m. an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to describe where the ball in the oxygen concentrator flowmeter should be placed if a resident is prescribed two liters of oxygen. LPN #4 stated the middle of the ball in the flowmeter should be placed at the line, at eye level. LPN #4 was made aware of the above findings.

On 7/20/17 at 2:25 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Oxygen Use, General" documented, "1. Oxygen therapy is administered to the resident only upon the written order of a licensed physician..."

The manufacturer's instruction manual for the oxygen concentrator documented in part, "To properly read the flowmeter, locate the prescribed flow rate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/Min (liters per minute) line prescribed."

No further information was presented prior to exit.

F 371 SS=D 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY — F 371

(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained directly

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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 the facility staff failed to store and prepare food in a sanitary manner in the kitchen.

1. Glasses of uncovered milk, juice and lemonade were observed in the refrigerator.

2. The cook's hair was observed out of the hair restraint being used.

The findings include:

1. Observation was made of the kitchen on 7/18/17 at 10:22 a.m. accompanied by other staff member (OSM) #2, the dietary manager. The "liquid" refrigerator was observed. There was a tray containing uncovered eight ounce glasses.

F 371

F-371
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

Glasses of uncovered milk, juice and lemonade were observed in the refrigerator on 7-18-17. The dietary manager discarded all uncovered beverages on 7-18-17.

Cook on 7-18-17 placed 3 hair nets on head to keep all hair restrained.

2. How will the facility identify other residents having the potential to be affected by the same practice?

Glasses of uncovered milk, juice and lemonade were observed in the refrigerator on 7-18-17. Dietary manger discarded all uncovered beverages on 7-18-17

Cook on 7-18-17 placed hair nets on head to keep all hair restrained.

Dietary staff that has not completed in-service by 8-14-17 will not be able to work in dietary until education is completed.

All newly hired dietary personal will be educated in orientation.

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F 371	Continued From page 87 The tray contained two lemonades, one juice and two milks. When asked if the glasses of liquids should be covered, OSM #2 stated, "Yes, Ma'am." The facility policy, "Infection Control and Prevention of Contamination" documented in part, "Guidelines: All refrigerated foods if removed from their original container, are securely covered, labels and dated appropriately." The executive director and director of nursing were made aware of the above findings on 7/20/17 at 4:05 p.m. No further information was provided prior to exit. 2. Upon entering the kitchen, OSM #4, the cook, was observed by the steam table, stirring a pan. Her hair net was on but it had risen in the back and didn't cover her hair at the base of her scalp. The front of the hairnet was not covering all of her hair at her forehead and there were sprigs of hair out of the net by her ears. An interview was conducted with OSM #2 on 7/18/17 at 10:42 a.m. When asked if the cook's hair should be fully contained in the hair net, OSM #2 stated, "Yes, it should be." The facility policy, "Associate Conduct" documented in part, "Guidelines: The Food and Nutrition Services associates wear a hair covering, which covers all unpinned hair at all times." The executive director and director of nursing were made aware of the above findings on 7/20/17 at 4:05 p.m.	F 371	3. What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur. Dietary manager will educate all dietary staff by 8-14-17 on storage and preparing food in a sanitary manner. Dietary manager will educate all dietary staff by 8-14-17 on wearing of hair net /restraint to cover all hair. Dietary manager and/or assistant dietary manager will audit 5 times a week for 30 days, then 3 times a week for 30 days, then 1 time a week for 30 days the covering of beverage for proper storing and preparing food in a sanitary manner in the kitchen and the wearing of a hair net /restraint that covers all hair. 4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and do not reoccur? Dietary manager will report finding of audits for proper storing of beverage and preparing food in a sanitary manner and the wearing of hair restraints to the quality assurance/performance improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nursing, Assist Director of Nursing, Social Services, Activities Director, Dietary Manager, Pharmacy consultant, Medical Director 08/23/17	

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F 371	Continued From page 88 No further information was provided prior to exit.	F 371		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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. (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-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F-431 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Director of nursing disposed of PPD (purified protein derivative) solution on 7-19-17. License nurse # 6 was educated on not leaving unsecured medication on top of cart unattended 8-5-17. Licensed nurse removed unsecured medications from the top of medication cart 7-19-17. 2. How will the facility identify other residents having the potential to be affected by the same practice? Unit managers checked all PPD (purified protein derivative) solution on 7-19-17 for labeling of date opened. No others were found not to be dated.	

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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
F 431	Continued From page 89 (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store medications in a safe manner on one of six medication carts and failed to label an open vial of medication in one of three medication rooms. 1. The nurse failed to secure medication while not at the medication cart for one of six medication carts. 2. The facility staff failed to label an open date on one vial of Aplisol PPD (purified protein derivative) solution (a medication used in the diagnosis of tuberculosis) in the Willow/Magnolia medication room. Per manufacturer's instructions, the medication must be discarded 30 days after being opened. The findings include:	F 431	3. What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur. Staff development coordinator, director of nursing and/or unit managers will educate all nursing staff by 8-14-17 on storage of drugs. Education will including not leaving medication on top of medication cart unattended. Education will include the dating of PPD (Purified Protein Derivative) solution when it open and that it expires in 30 days once it is open. All nurses who have not received education by 8-14-17 will not be able to provide direct care until in-service is completed. Newly hired nurses will be educated in orientation. Director of Nursing and/or unit managers will complete audits 5 times a week for 30 days, then 3 times a week for 30 days than 1 time a week for 30 days for dating of PPD solution when opened and discarded in 30 days.	

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Observation was made on 7/19/17 of the medication cart on the 200 unit at 10:32 a.m. The nurse was not at the medication cart. Observed on the top of the medication cart were three medication cards with medications still in the cards. The medications were for three different residents. The medications were: Amox-Clav 875-125 MG BID, this card contained two pills. (Brand name: Augmentin - AUGMENTIN is an oral antibacterial - antibiotic (1)) Florastor 250 MG BID; this card contained six capsules - a probiotic - (Probiotics are live microorganisms [in most cases, bacteria] that are similar to beneficial microorganisms found in the human gut. They are also called "friendly bacteria" or "good bacteria." Probiotics are available to consumers mainly in the form of dietary supplements and foods (2)). Vitamin C 250 MG BID; this card contained five tablets -(Vitamin C, also known as L-ascorbic acid, is a water-soluble vitamin that is naturally present in some foods, added to others, and available as a dietary supplement (3)).

The nurse LPN (licensed practical nurse) #6 returned to her medication cart, from out of a room three doors down from where the medication cart was stored, on 7/19/17 at 10:35 a.m. When asked if medications are allowed on the cart when she is in a room with a resident, LPN #6 stated, "They belong in the med (medication) room. I got side tracked." When asked if the medication should have been secured before she left her cart, LPN #6 stated, "Yes."

An interview was conducted with LPN #3, the unit manager, on 7/19/17 at 1:58 p.m. When asked if medications can be stored on top of the medication cart when the medication cart is out of

Director of nursing and/or unit managers will audit medication carts 5 times a week for 30 days, then 3 times a week for 30 days, then 1 time a week for 30 days for unsecured medications.

4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and do not reoccur?

Director of nursing will report finding of audits for storage of drugs to the quality assurance/performance improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nursing, Assist Director of Nursing, Social Services, Activities Director, Dietary Manager, Pharmacy consultant, Medical Director

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a nurse's line of sight, LPN #3 stated, "No."

The executive director, ASM (administrative staff member) #1 and the director of nursing, ASM #2 were made aware of the above findings on 7/19/17 at 5:18 p.m.

The policy for storing medications was requested on 7/20/17 at 3:00 p.m.

The policy, "Medication Storage & Security in the Facility" was received on 7/20/17 at 5:15 p.m. The policy documented in part, "Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to have access...2. Medication rooms, carts and medications supplies are locked or attended by persons with authorized access...8. Except for those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area...19. Medications that are discontinued or medications that are left at the facility when the resident is discharged are removed from the medication cart and place in the locked medication room in a designated area until the discontinued medication are removed from the facility."

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?id=44390

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(2) This information was obtained from the following website: https://nccih.nih.gov/health/probiotics.
(3) This information was obtained from the following website: https://ods.od.nih.gov/factsheets/VitaminC-HealthProfessional/
2. The facility staff failed to label an open date on one vial of Aplisol PPD (purified protein derivative) solution (a medication used in the diagnosis of tuberculosis (1)) in the Willow/Magnolia medication room. Per manufacturer's instructions, the medication must be discarded 30 days after being opened.

On 7/19/17 at 2:20 p.m. observation of the Willow/Magnolia medication room was conducted. The medication refrigerator contained one open vial of PPD solution (approximately half full). No open date was documented on the vial or the container that contained the vial. At this time an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 confirmed the vial and container were not labeled with an open date. LPN #5 was asked what the expiration date of the PPD solution was after the vial was opened. LPN #5 stated on most items she writes a standard 30 day discard date unless there is an obvious expiration date. LPN #5 stated she goes to the staff education nurse if she has any questions. LPN #5 was asked if the vial should have been labeled with an open date. LPN #5 stated, "I probably would. Anything you open you label with a date."

The manufacturer's instructions documented, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..."

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On 7/19/17 at 5:20 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Medication Storage & Security in the Facility" documented, "Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier..."

No further information was presented prior to exit.

(1) This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1e91a67c-1694-4523-9548-58f7a8871134

F 502 SS=D — 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, clinical record review, and facility document review, it was determined that the facility staff failed to perform a laboratory test as ordered by the physician for one of 29 residents in the survey sample, Resident #3.

The facility staff failed to perform laboratory (lab) test for PTH (parathyroid hormone (1)) and phosphorus levels (2) for Resident #3 as ordered

F 502

F-502
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?
Director of nursing notified physician on 8-1-17 of missed labs for PTH (parathyroid hormone) and phosphorus level.

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by the physician on 5/10/17.

The findings include:

Resident #3 was admitted to the facility on 2/23/17 and most recently readmitted on 6/1/17 with diagnoses including, but not limited to: history of bladder and kidney cancer, heart attack and right above the knee amputation. On the most recent MDS (minimum data set), a 14 day Medicare assessment with an assessment reference date of 6/15/17, Resident #3 was coded as having no cognitive impairment for making daily decisions.

A review of Resident #3's clinical record revealed the following physician's order written and signed by the physician on 5/10/17: "CMP (comprehensive metabolic panel (3)), Phos (phosphorus), PTH."

A review of the laboratory results for Resident #10 failed to reveal evidence of the Phos and PTH tests ordered on 5/10/17 by the physician.

On 7/20/17 at 8:00 a.m., ASM (administrative staff member) #2, the director of nursing, stated unit managers are responsible for monitoring all laboratory tests. ASM #2 stated: "They have a system to follow up and to track them." She stated that if results do not come in timely from the lab, unit managers are to track the missing lab tests and to call the lab for the test results."

On 7/20/17 at 8:55 a.m., LPN (licensed practical nurse) #3, a unit manager, was interviewed. She stated that the nurse who transcribes the physician's lab (laboratory) order enters it into the computer software system in order to generate a

2. How will the facility identify other residents having the potential to be affected by the same practice?
Unit manager completed lab audit by 8-4-17 of all residents' labs for the months of May, June, July 2017. Unit manager notified physician of residents with missing labs. New orders obtained were implemented by unit managers on 8-3-17.

3. What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.
Staff development coordinator, director of nursing and/or unit managers will educate license nurses by 8-14-17 of lab process. License nurse will place lab order on treatment record for the day lab is to be drawn. The license nurse will put lab test into lab system on the computer. License nurse will print 2 copies of lab test ordered. Place one in unit manager box and one in the lab book under the correct date lab is to be obtained. License nurse working Birch hall will pull labs from the fax machine and give to appropriate nurses. Resident's assigned nurse will notify physician of lab results.

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lab slip. She stated the nurse prints two copies, one copy goes in the lab book, and one copy goes to the unit manager. LPN #3 stated she keeps a log of all lab tests that are to be performed so that she can follow up to make sure all tests have been done. She stated the unit manager is responsible for checking the lab slip against the actual physician's order to make sure everything the physician has ordered is included on the lab slip. When asked to review the 5/10/17 lab order for Resident #3, and to check his chart for results of these tests, LPN #3 stated she would do so. LPN #3 returned to the survey team at 9:05 a.m. and stated the PTH and phosphorus tests were not performed as ordered for Resident #3. LPN #3 stated: "Someone must have just missed it."

On 7/20/17 at 10:10 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy "Laboratory Order Sheet" revealed no information related to the facility staff performing the correct physician-ordered laboratory tests.

(1) "Parathyroid hormone (PTH) is released by the parathyroid glands. The 4 tiny parathyroid glands are located in the neck, near or attached to the back side of the thyroid gland. The thyroid gland is located in the neck, just above where your collarbones meet in the middle. PTH controls calcium, phosphorus, and vitamin D levels in the blood. It is important for regulating bone growth." This information is taken from the website https://medlineplus.gov/ency/article/003690.htm.

All nurses who have not completed in-services by 8-14-17 will not be allowed to provide direct care until in-services are completed.
Newly hired nurses will be educated in orientation.

Director of nursing and/or unit managers will audit in grand rounds (am clinical meeting) the obtaining of labs/ results of labs received and physician notification

5 times a week for 30 days ,then 3 times a week for 30 days ,then 1 time a week for 30 days.

4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and do not reoccur?

Director of nursing will report finding of lab audits to the quality assurance/ performance improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nursing, Assist Director of Nursing, Social Services, Activities Director, Dietary Manager, Pharmacy consultant, Medical Director

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(2) "Phosphorus is a mineral the body needs to build strong bones and teeth. It is also important for nerve signaling and muscle contraction. This test is ordered to see how much phosphorus is in your blood. Kidney, liver, and certain bone diseases can cause abnormal phosphorus levels." This information is taken from the website https://medlineplus.gov/ency/article/003478.htm.

(3) "A comprehensive metabolic panel (Chem 14) is a group of blood tests. They provide an overall picture of your body's chemical balance and metabolism. Metabolism refers to all the physical and chemical processes in the body that use energy." This information is taken from the website https://www.nlm.nih.gov/medlineplus/ency/article/003468.htm.

According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007, Page 165: "Laboratory tests are always interpreted in relation to the client's underlying health problems and treatment modalities. These results can also identify actual or potential health problems....Sometimes, laboratory tests and diagnostic procedures are used to judge the effectiveness of nursing interventions or medical treatment."

F 507 SS=E — 483.50(a)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS — F 507

(a) Laboratory Services

(2) The facility must-

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(iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.
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 file lab (laboratory) results on the clinical record for four of 29 residents in the survey sample, Residents #3, #6, #1, and #16.

1. The facility failed to file the results for a CBC (complete blood count (1)), CMP (complete metabolic profile (2)), and sed (sedimentation) rate (3)) on the clinical record for Resident #3.

2. The facility staff failed to file the results for a CBC and two BMPs (basic metabolic panels (4)) on the clinical record for Resident #6.

3. The facility staff failed to file a CBC laboratory test result in Resident #1's clinical record.

4. The facility staff failed to file a laboratory test result ordered by the physician on 6/1/17 in Resident #16's clinical record.

The findings include:

1. The facility failed to file the results for a CBC (complete blood count (1)), CMP (complete metabolic profile (2)), and sed (sedimentation) rate (3)) on the clinical record for Resident #3.

Resident #3 was admitted to the facility on 2/23/17 and most recently readmitted on 6/1/17 with diagnoses including, but not limited to: history of bladder and kidney cancer, heart attack

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?
Resident # 3 lab ordered on 6-10-17 was filed on chart by Health information management for CBC (complete blood count) CMP (complete metabolic level) and sedimentation rate.

Resident # 6 labs obtained on 7-10-17 CBC and 2 BMPs was filed on chart by Health information management.

Resident #1 labs for CBC on 7-6-17 was filed by Health information management on chart.

Resident # 16 labs for 6-1-17 was filed on chart by Health information management.

2. How will the facility identify other residents having the potential to be affected by the same practice?

Unit manager completed lab audit by 8-4-17 of all residents' labs for the months of May, June and July 2017. Physician notified of any missing labs on 8-4-17. New orders obtained per physician.

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and right above the knee amputation. On the most recent MDS (minimum data set), a 14 day Medicare assessment with an assessment reference date of 6/15/17, Resident #3 was coded as having no cognitive impairment for making daily decisions.

A review of Resident #3's clinical record revealed the following physician's order written and signed by the physician on 6/10/17: "CBC, CMP, Sed rate."

Further review of Resident #3's clinical record failed to reveal results from these laboratory (lab) tests.

On 7/19/17 at 5:20 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns.

On 7/20/17 at 8:00 a.m., ASM #2 stated when the lab results come back to the facility, the physician is to review the lab results, then the results are to go to the medical records clerk to be placed on the clinical record.

On 7/20/17 at 8:55 a.m., LPN (licensed practical nurse) #3, a unit manager, presented the surveyor with the laboratory test results for the 6/10/17 tests. When asked where she obtained the results, LPN #3 stated: "I had them faxed over from the lab. They were not on the chart here." She stated the results should have been filed on the resident's clinical record. When asked about the process for filing laboratory test results on the chart, LPN #3 stated the lab faxes the results to a nurses' station. The nurse at that station distributes the results to the appropriate

F 507 3. What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.
Staff development coordinator, director of nursing and/or unit managers will educate license nurses by 8-14-17 of lab process for filing of lab reports timely.
Director of nursing and/or unit managers will audit in grand rounds (am clinical meeting) the filing of lab on chart timely 5 times a week for 30 days, then 3 times a week for 30 days, then 1 time a week for 30 days.

All nurses who have not completed in-services by 8-4-17 will not be allowed to provide direct resident care until in-services are completed.
Newly hired nurses will be educated on process in orientation.

4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and do not reoccur?
Director of nursing will report finding of the filing of labs timely to the quality assurance/performance improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nursing, Assist Director of Nursing, Social Services, Activities Director, Dietary Manager, Pharmacy consultant, Medical Director

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unit. The nurse working with the tested resident is responsible for notifying the physician of any abnormal laboratory results. She stated the nurse places the lab results into a folder for the physician or NP (nurse practitioner) to review the next morning. The physician or NP reviews and signs the lab result. The results then go back to the unit manager, who checks off that he/she has received the results. The results are then given to the medical records clerk to be filed on the resident's clinical record. She stated the facility staff had recently become aware of some concerns regarding the filing laboratory records on resident records, and had done "some education." LPN #3 stated the education was not yet complete with staff.

A review of the facility policy "Laboratory Order Sheet" failed to reveal information related to resident lab results being filed on the clinical record.

(1) "This test measures number of red blood cells white blood cells total amount of hemoglobin and the fraction of the blood composed of red blood cells , and measures the number of different types of white blood cells." This information is taken from the website http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0004108/

(2) "A comprehensive metabolic panel (Chem 14) is a group of blood tests. They provide an overall picture of your body's chemical balance and metabolism. Metabolism refers to all the physical and chemical processes in the body that use energy." This information is taken from the website https://www.nlm.nih.gov/medlineplus/ency/article/

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003468.htm

(3) "ESR stands for erythrocyte sedimentation rate. It is commonly called a 'sed rate.' It is a test that indirectly measures how much inflammation is in the body." This information is taken from the website https://medlineplus.gov/ency/article/003638.htm.

According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007. Page 237, "Clearly documented information on the client record communicates the plan of care and the client's progress to all members of the healthcare team. Team members who interact with the client at different times and in different ways get a clear picture of what took place in their absence. This communication ensures continuity of care and provides essential data for revision or continuation of care."

2. The facility staff failed to file the results for a CBC and two BMPs (basic metabolic panels (4)) on the clinical record for Resident #6.

Resident #6 was admitted to the facility on 3/3/12 and most recently readmitted on 5/1/16 with diagnoses including, but not limited to: Alzheimer's disease and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 6/8/17, Resident #6 was coded as having both short and long term memory deficits, and as being moderately cognitively impaired for making daily decisions.

A review of Resident #6's clinical record revealed the following orders:
- Written and signed by the physician on 6/30/17:

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"CBC, BMP next week (Thurs [Thursday] is okay 7/6."
- Written and signed by the physician on 7/10/17: "BMP Tues (Tuesday) 7/11."

Further review of Resident #6's clinical record failed to reveal the results of these tests ordered on 6/30/17 and 7/10/17.

On 7/19/17 at 5:20 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns.

On 7/20/17 at 8:55 a.m., LPN (licensed practical nurse) #3, a unit manager, presented the surveyor with the laboratory test results for the 6/30/17 and 7/10/17 tests. When asked where she obtained the results, LPN #3 stated: "I had them faxed over from the lab. They were not on the chart here." She stated the results should have been filed on the resident's clinical record.

No further information was provided prior to exit.

(4) "This is a blood test used to evaluate the kidneys, liver, blood sugar, protein, electrolytes and acid/base balance." This information is taken from the website http://www.nlm.nih.gov/medlineplus/ency/article/003468.htm.

3. The facility staff failed to file a CBC (complete blood count (8)) laboratory test result in Resident #1's clinical record.

Resident #1 was admitted to the facility on 12/28/17 with a recent readmission on 5/30/17,

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with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), severe peripheral artery disease (any abnormal condition affecting the arteries outside the heart (2)), above the knee amputation, atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)), cardiac disease, aneurysm (a saclike widening in a blood vessel (4)), gastrointestinal bleed and osteoarthritis (the most common form of arthritis occurring mostly in the elderly, characterized by degenerative changes in the joints (5)).

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 5/11/17, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating he was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living, except eating in which he was coded as requiring supervision of one staff member.

The physician order dated, 6/30/17 at 7:30 p.m. documented, "CBC (complete blood count)* Thurs (Thursday) 7/6 - recheck leukocytosis (abnormal increase in the number of leukocytes in the blood (6)), WBC (white blood cell) (an arrow pointing upward indicating elevated) 6/6 & 6/14 secondary to colitis (inflammation of the colon (7))."

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*CBC can help detect blood diseases and disorders, such as anemia, infections, clotting problems, blood cancers, and immune system disorders. This test measures many different parts of your blood. (8)

Review of the clinical record failed to evidence the results of the CBC that was to be drawn on 7/6/17.

The comprehensive care plan dated, 12/28/16 and revised on 4/26/17, documented in part, "Problem: Resident is at risk for cardiac distress due to Dx (diagnosis) of CAD (coronary artery disease), HTN (high blood pressure) and A. Fib (atrial fibrillation)." The "Approaches" documented in part, "Monitor labs (laboratory tests) and report results."

The results of the CBC were requested on 7/19/17. A copy of the results was received on 7/21/17 at 8:00 a.m. from the director of nursing, ASM (administrative staff member) #2. When asked if the results had been on the clinical record, ASM #2 stated they had obtained the laboratory test results from the computer system with the laboratory. The director of nursing confirmed the results of the CBC for Resident #1 were not on the clinical record.

An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/20/17 at 8:54 a.m. When asked about the process for obtaining and ensuring the laboratory test results are on the clinical record, LPN #3 stated, "I check to make sure everything is done. The lab (laboratory) will fax us the results to the nurse's

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station and the nurse who gets the results will distribute them through the building. The nurse working is responsible to notify the doctor if the results are abnormal. If the results are normal they go in the doctor's folder for the next morning." When asked how often the doctor and nurse practitioner are here, LPN #3 stated, "They are here Monday through Friday and on call on the weekends." LPN #3 stated once the doctor signs them off they come back to me (unit manager) and I check off that the results have been received. Then they are given to HIM (health information management) to be filed in the records. LPN #3 stated, "We identified that we had a problem with following up on the laboratory results last week and have just started a check list."

The executive director, ASM #1 and director of nursing, ASM #2 were made aware of the above findings on 7/20/17 at 10:12 a.m.

A copy of the policy for filing laboratory tests was requested on 7/20/17 at 3:00 p.m. from the executive director. The policy received on 7/20/17 at 5:15 p.m. was titled, "Laboratory Order Sheet" and did not address the filing of the results in the clinical record.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 447.
(3) Barron's Dictionary of Medical Terms for the

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Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 34.
(5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 422.
(6) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 333.
(7) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 132.
(8) This information was obtained from the following website: https://www.nhlbi.nih.gov/health/health-topics/topics/bdt/types

4. The facility staff failed to file a laboratory test result ordered by the physician on 6/1/17 in Resident #16's clinical record.

Resident #16 was admitted to the facility on 4/2/14 with a most recent readmission on 12/7/16 with diagnoses that included but were not limited to: high blood pressure, shortness of breath, edema, pain, history of respiratory failure, anemia and chronic kidney disease and obesity.

The most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 6/15/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff

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members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided.

The physician order had no date but had a time of 11:30 a.m. and singed by the physician on 4/21/17, documented, "Labs (laboratory tests) to be drawn on June 1, 2017. CMP (comprehensive metabolic panel - is a group of tests that measures different chemicals in the blood. These tests are usually done on the fluid (plasma) part of blood (1)), Magnesium (Magnesium, an abundant mineral in the body, is naturally present in many foods, added to other food products, available as a dietary supplement, and present in some medicines [such as antacids and laxatives] (2)), phosphorus (Phosphate is one of the most abundant minerals in the body, and its serum levels are regulated by a complex set of processes occurring in the intestine, skeleton, and kidneys (3)), PTH (Parathyroid hormone is the major hormone regulating calcium metabolism and is involved in both catabolic and anabolic actions on bone (4)) and CBC for anemia and chronic kidney disease."

A review of the clinical record failed to evidence the results of the above ordered laboratory tests.

The comprehensive care plan dated, 1/8/15 with a target date of 9/28/17, documented in part, "Problems: Resident is at risk for cardiac distress due to Dx (diagnosis) of CHF (congestive heart failure), HTN (high blood pressure) Afib (atrial fibrillation)." The "Approaches" documented in part, "Monitor labs (laboratory tests) and report results."

On 7/20/17 at 12:42 p.m. LPN (licensed practical

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nurse) #4, the unit manager was asked to locate the laboratory results ordered for 6/1/17.

On 7/20/17 at 12:58 p.m. LPN #4 returned to this surveyor and presented the laboratory test results for 6/1/17. When asked where he got the results from, LPN #4 stated, "I got them off the laboratory website." When asked if they were on the clinical record, LPN #4 stated, "No, Ma'am."

The executive director and the director of nursing were made aware of the above findings on 7/20/17 at 4:05 p.m.

No further information was provided prior to exit.

References:
(1) This information was obtained from the following website: https://medlineplus.gov/metabolicpanel.html.
(2) This information was obtained from the following website: https://ods.od.nih.gov/factsheets/Magnesium-HealthProfessional/
(3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3461213/
(4) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3842136/

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F 513 SS=D 483.50(b)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED

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(b) Radiology and other diagnostic services.

(2) The facility must-

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(iv) File in the resident's clinical record signed and dated reports of radiologic and other diagnostic services.
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 file a radiology result in the clinical record for two of 29 residents in the survey sample, Residents #9 and 1.

1. The facility staff failed to file ultrasound results in the clinical record for Resident #9.

2. The facility staff failed to file x-ray radiology results ordered by the physician in Resident #1's clinical record.

The findings include:

1. The facility staff failed to file ultrasound results in the clinical record for Resident #9.

Resident #9 was admitted to the facility on 6/6/17 with the following diagnoses; cellulitis (a skin infection) of both lower legs, metabolic encephalopathy (a swelling of the brain), high blood pressure, dementia and congestive heart failure.

Resident #9's most recent MDS (minimum data set), a 5 day assessment, with an ARD (assessment reference date) of 6/13/17 coded Resident #9 as scoring a 12 out of a possible 15 on the BIMS (brief interview for mental status), indicating that Resident #9 was moderately cognitively impaired with daily decision making.

F-513
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

Resident # 9 ultrasound was obtained on 7-19-17 and filed on chart by Health information management. Physician was notified of results of ultrasound. No new orders given.

Resident # 1 x-ray was filed on chart 7-20-17 by Health information management. Physician was notified of results of x-ray. No new orders given.

2. How will the facility identify other residents having the potential to be affected by the same practice?
Unit managers audited all resident who had ultrasound and x-rays obtained for the past 30 days for timely filing of reports. All radiology report are on charts.

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A review of Resident #9's clinical record revealed the following physician order; "6/20/17 US (ultrasound) RLE (right lower extremity) tomorrow r/o (rule our) DVT (deep venous thrombosis [a blood clot])."

Further review of Resident #9's clinical record did not reveal the results of the ultrasound in the clinical record.

On 7/19/17 at approximately 2:00 p.m. OSM (other staff member) #3, the medical records director, was asked to provide a copy of the ultrasound report that was completed on 6/21/17 for Resident #9.

On 7/20/17 at 7:55 a.m. ASM (administrative staff member) #2, the director of nursing, provided a copy of Resident #9's ultrasound report dated 6/21/17. When asked where the report had been filed, ASM #2 stated they did not have the report in the clinical record. ASM #2 further stated, "We have been having trouble getting faxes from (name of radiology company) and we just never got it." ASM #2 was asked who was responsible for ensuring that results are in the clinical record. ASM #2 stated, "When results coming in the MD (medical doctor) receives it for review and then it goes to medical records. The unit manager is responsible for tracking the results to ensure that they are received." A policy was requested at this time for a complete and accurate clinical record.

No further information was provided prior to the end of the survey process.
2. The facility staff failed to file x-ray radiology results ordered by the physician in Resident #1's clinical record.

3. What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.
Staff development coordinator, director of nursing and/or unit managers will educate license nurses by 8-14-17 of process for filing radiology reports.
All nursing staff that have not been in-services by 8-14-17 will not be allowed to provide direct resident care until in-services are completed.

Newly hired nurses will be educated in orientation.

Director of nursing and/or unit managers will audit in grand rounds (am clinical meeting) any radiology report obtained for follow up and filing timely 5 times a week for 30 days, then 3 times a week for 30 days, then 1 time a week for 30 days.

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Resident #1 was admitted to the facility on 12/28/17 with a recent readmission on 5/30/17, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), severe peripheral artery disease (any abnormal condition affecting the arteries outside the heart (2)), above the knee amputation, atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)), cardiac disease, aneurysm (a saclike widening in a blood vessel (4)), gastrointestinal bleed and osteoarthritis (the most common form of arthritis occurring mostly in the elderly, characterized by degenerative changes in the joints (5)).

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 5/11/17, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating he was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living, except eating in which he was coded as requiring supervision of one staff member.

A physician order dated, 6/12/17 at 11:55 a.m. documented, "Chest x-ray (2) (two views) also T spine [throacic spine] (2) (two views) (attn. [attention] L (left) thoracic) pain, L mid-back."

Review of the clinical record failed to reveal the

4. How will the facility monitor the Corrective plan to ensure the deficient practice was corrected and do not reoccur?

Director of nursing will report finding of audits of filing on chart of radiology reports to the quality assurance/performance improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nursing, Assist Director of Nursing, Social Services, Activities Director, Dietary Manager, Pharmacy consultant, Medical Director

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results for these x-rays.

The result of the 6/12/17, physician ordered x-rays were requested on 7/19/17. A copy of the physician ordered x-ray results for Resident #1, were received on 7/21/17 at 8:00 a.m. from the director of nursing, ASM (administrative staff member) #2. When asked where the results came from, ASM #2 stated they had called the radiology company and had them fax over the results. ASM #2, the director of nursing, confirmed the physician ordered x-ray results were not in the clinical record.

An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/20/17 at 8:54 a.m. When asked about the process followed for when a physician orders an x-ray, LPN #3 stated, "The doctor give us an order. The nurse taking off the order calls the provided to order the test. They (the provider) fax over a form to be filled in and the form is given to the tech (technician) when they arrive." When asked how the facility ensures the results for physician ordered radiology tests are received back, LPN #3 stated, "I don't have a process for that. We've had issues getting the faxes from them (the provider). They come back with headers and the rest blank. Then we have to call to get the full report." When asked who was going back to ensure all the radiology test results ordered for residents' are received back, LPN #3 stated, "We don't have a plan in place. There is not a flow sheet that says we got this back and the doctor signed it off." When asked how the results are placed on the clinical record, LPN #3 stated, "If the results are signed off by the doctor, they are then given to HIM (health information management) to file in the record." When asked

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why Resident #1's results were not in the clinical record, LPN #3 stated, "I can't tell you what happened with that. Sometimes we or the nurse practitioner will call to get results and they just give us a verbal report."

The executive director ASM #1 and director of nursing, ASM #2 were made aware of the above findings on 7/20/17 at 10:12 a.m.

A policy on the processing of radiology reports were requested on 7/20/17 at 3:00 p.m. from the executive director.

On 7/20/17 at 5:15 p.m. administrative staff member (ASM) #4, the nurse consultant, informed this surveyor that they did not have a policy on filing x-ray reports.

No further information was provided prior to exit.

References:

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 447.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 34.
(5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 422.

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F 514 SS=D	Continued From page 113 483.70(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- (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 resident interview, staff interview,	F 514	F 514	

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facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for three of 29 residents in the survey sample, Resident #25, Resident #8 and Resident #1.

1. The facility staff failed to document a progress note, or follow up notes, when Resident #25 was disempacted by a nurse.

2. The facility staff failed to document Resident #8's physician was made aware of a weight gain greater than two pounds on 7/16/17.

3. The facility staff failed to document the time Ambien (used for the inability to sleep (1)) was administered to Resident #1 on the MAR (medication administartion record) and the effectiveness of the medication.

The findings include;

1. The facility staff failed to document a progress note, or follow up notes, when Resident #25 was disempacted by a nurse.

Resident #25 was admitted to the facility on 6/16/17 with diagnoses that included, but were not limited to; high blood pressure, diabetes, low blood pressure, chronic kidney disease, obesity and hemorrhoids.

Resident #25's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/13/17, coded Resident #25 as scoring a 14 out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #25 is cognitively intact.

F-514

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

Resident #25 physician was notified on 7-20-17 of resident's dis-impaction. Physician assessed resident #25 and documented assessment in progress note. No new orders were obtained. On 7-22-17 new order received for hemorrhoid crème prn.

Nurse #13 was suspended on 7-20-17 and corrective action completed on 7-31-17. Nurse #13 was directed to review Virginia scope of practice for licensed nurses. She was placed on an action plan to include re-orientation from 7-25-17 through 7-31-17. Educated by Staff development coordinator educated nurse # 13 on change of condition and notification to physician for concerns of hemorrhoids, constipation unrelieved by bowel protocol and rectal pain.

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Resident #25 was also coded as requiring maximum assistance of one person for toileting.

On 7/18/17 at 3:30 p.m. an interview was conducted with Resident #25. Resident #25 was tearful and stated that she suffered from hemorrhoids, that she was recently at her surgeons office for an unrelated reason and that he had told her that she needed to be on a stool softener. Resident #25 stated that she did not get the stool softener for several days and as a consequence stated "I got so packed up I couldn't stand it, the nurse had to pull it out. I didn't even know you could do that." Resident #25 further stated, "I got chills and had to stay in the bed all day. Now every time I have a bowel movement I am on fire, I have begged for a salve (ointment for the rectum) but they (nursing) say then don't have any. I've been using something else to help with the burning."

A review of Resident #25's clinical record did not reveal any nursing progress notes that referenced disimpaction or Resident #25's concern for constipation.

A review of Resident #25's physician orders revealed the following; "7/14/17 11:50 a.m. Prep (preparation) H (an ointment used to treat hemorrhoids) ointment to hemorrhoids BID (two times per day) x (for) 1 (one) wk (week). D/C (discontinue) fiber laxative. Colace 100 mg (milligrams) PO (by mouth) daily for stool softener. Fiber laxative 2 (two) tabs (tablets) po qhs (every bedtime) impaction."

A review of Resident #25's MAR (medication administration record) dated July 2017 revealed, in part, the following entries; "Fiber laxative (an

Resident #8 discharged

Resident #1 has Ambien ordered prn. License nurse will administer medication as per order and document on medication administration record the administration of medication and on back of medication administration record the effectiveness of Ambien.

2. How will the facility identify other residents having the potential to be affected by the same practice?

All other residents using hemorrhoid crèmes were audited by unit manager on 8-2-17 for dis-impaction. Only one other resident 13123 was receiving hemorrhoid crème. Resident has not been dis-impacted. No other residents have been dis-impacted.

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over the counter supplement to help reduce constipation) Take 2 tabs (tablets) PO QHS dx. (diagnosis) Impaction." From 7/14/17 through 7/19/17 there are nurses initials indicating this was administered at 9:00 p.m. each evening. "Colace (a stool softener) 100 mg (abbreviation for 1) PO daily Dx. Constipation." From 7/15/17 through 7/20/17 there are nurses initials indicating this was administered at 9:00 a.m. each day. There were no order entries or nursing initials for preparation H to be applied to the hemorrhoids.

A review of Resident #25's comprehensive care plan dated 6/16/2016 revealed, in part, the following documentation; "Problems: Resident is at risk for pain. Approaches: Observe for s/s (signs and symptoms) constipation and administer bowel protocol PRN (as needed)." Further review did not reveal any documentation regarding hemorrhoids.

On 7/20/17 an interview was conducted with LPN (licensed practical nurse) #13, a floor nurse working with Resident #25. LPN #13 was asked what should be done if a resident states he/she is constipated. LPN #13 stated, "If I don't have an order for laxatives then I ask the nurse practitioner for an order." LPN #13 was asked what should be done if a resident states that he/she is unable to evacuate their bowels. LPN #13 stated that normally she would go back to the nurse practitioner. LPN #13 was asked if she would normally attempt to disimpact the resident. LPN #13 responded, "No but one resident did recently beg me to do that (disimpact), (name of Resident #25)." LPN #13 stated that this happened on 7/14/17. LPN #13 was asked if she obtained an order to disimpact Resident #25,

Director of nursing reviewed all residents with orders for daily and weekly weights with physician on 8-1-17. Director of nursing documented notification of weight in nurses notes on 8-1-17. New orders received were written by Director of nursing on 8-2-17. Resident's weights will be obtained per physician's orders and change of condition policy to include weight loss, weight gains per physician's orders.

Unit managers will audit all residents receiving prn Ambien for documentation on medication administration record and for effectiveness on back of Mar.

3. What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.

Staff development coordinator, director of nursing, and/or unit managers will educate license nurses by 8-14-17 on standards of nursing practice. No residents will be dis-impacted. Physician to be notified of any change in GI status involving need for dis-impaction, unrelieved constipation with current bowel regimen or treatment for hemorrhoids.

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LPN #13 stated that she mentioned it to (name of nurse practitioner) and received an order for a stool softener. LPN #13 was asked if she was aware of Resident #25 having hemorrhoids. LPN #13 stated that she was. LPN #13 was asked if Resident #25 complained to her of her bottom being sore following the disimpaction, LPN #13 stated, "She said it burned when she pooped." LPN #13 was asked if she had anyone assess Resident #25's bottom related to her ongoing complaints. LPN #13 stated that she did not. When asked if she had looked at the hemorrhoids, LPN #13 stated, "I did look at the hemorrhoids and they were very swollen." LPN #13 was asked if she documented about the disimpaction or the assessment she had done, LPN #13 stated that she did not.

On 7/20/17 at 1:55 p.m. an interview was conducted with ASM (administrative staff member) #3, the nurse practitioner. ASM #3 was asked if LPN #13 had approached her on 7/14/17 about Resident #25 being very constipated, and was asked if LPN #13 had received a verbal order to disimpact Resident #25. ASM #3 stated that she had not worked on 7/14/17 and that (name of ASM #5, the medical doctor) was working on his own that day. ASM #3 further stated that (name of Resident #25) had stopped her in the hall on the following Tuesday (7/18/17) and told her that a "nurse" had to "dig out" the stool. When asked if ASM #3 conducted an examination after what Resident #25 had told her, ASM #3 stated that she had not. ASM #3 was asked if she was aware of an order for Resident #25 to be disimpacted, ASM #3 stated no."

On 7/20/17 at 2:30 p.m. an interview was conducted with ASM #5, the medical doctor.

F 514 Staff development coordinator, director of nursing and/or unit managers will educate license nurses by 8-14-17 on physician notification/change of condition as directed by physician's orders and change of condition policy to included weight loss, weight gains per physician orders.

Staff development coordinator, director of nursing, and/or unit managers will educate license nurses of documentation for prn medications by 8-14-17. Nurses will document administration of Ambien on the medication administration record and the effectiveness on the back of the medication administration records.

All nursing staff that have not completed in-services will not be allowed to provide direct care until in-services are completed.

Newly hired nurses will provided education in orientation.

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ASM #5 was asked if he had given a verbal order to disimpact Resident #25 on 7/14/17. ASM #5 stated, "I remember the nurse coming to me, but I don't remember her asking about disimpacting. ASM #5 stated, "I remember that the nurse said she (Resident #25) was impacted and not that she had disimpacted her. I wrote orders for stool softeners. I can't say what else happened. I don't know."

On 7/20/17 at 3:00 p.m. an interview was held with ASM #2, the director of nursing, and LPN #13. ASM #2 was made aware of the concern of LPN #13 performing a disimpaction on Resident #25 without a physician order and LPN #13 failed to document the disimpaction of the resident in the clinical record. ASM #2 verified that a physician order would have to be obtained for the procedure and should not have been done without an order.

A review of the facility document titled "Physician Orders" revealed, in part, the following documentation; "Policy: A physician must provide orders for the resident's immediate care. Procedure: Physician orders include the following; Special medical procedures required for the safety and well-being of the resident. Note: Medications, diets, therapy and any treatment may not be administered to the resident without a written order from the attending physician."

No further information was provided prior to the end of the survey process.

2. The facility staff failed to document Resident #8's physician was made aware of a weight gain greater than two pounds on 7/16/17.

Bowel Movement report will be printed five times a week by unit manage for review of frequency of bowel movements. 24 hour report will be reviewed daily for any complaints of unrelieved constipation with current bowel regimen and/or treatment for hemorrhoids with rectal pain during grand rounds (am clinical meeting). Audit will occur 5 times a week for 30 days, then 3 times a week for 30 days, and 1 time a week for 30 days.

Director of nursing and/or unit manager in grand rounds (am clinical meeting) will audit daily and weekly weight, and physician or family nurse practitioner notification 5 times a week for 30 days, 3 times a week for 30 days, the one time a week for 30 days.

Director of nursing and/or unit managers will audit residents who receive Ambien for documentation on medication administration sheet and the effectiveness on back of the medication administration record 5 times a week for 03 days, 3 times a week for 30 days and 1 time a week for 30 days.

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Resident #8 was admitted to the facility on 7/6/17. Resident #8's diagnoses included but were not limited to: diabetes, congestive heart failure and a diabetic foot ulcer. Resident #8's admission MDS (minimum data set) was not complete. An initial data collection tool dated 7/6/17 documented Resident #8 was alert and oriented.

Review of Resident #8's clinical record revealed an order dated 7/6/17 for, "Daily weight if gains 2 lbs (pounds) or more in a day notify MD (medical doctor)/NP (nurse practitioner). Provide copy of weights to MD/NP weekly on Wednesday..."

Resident #8's July 2017 TAR (treatment administration record) documented, "Daily weight if gains 2lbs or more in a day notify MD/NP. Provide copy of weights to MD/NP weekly on Wednesday..." The TAR documented a weight of 193.2 lbs on 7/15/17 and a weight of 196.7 lbs on 7/16/17. Further review of Resident #8's clinical record (including the back of the TAR, computer system and nurses' notes) failed to reveal the resident's MD/NP was notified regarding the weight gain.

On 7/19/17 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #5 (the nurse who documented Resident #8's weight on the TAR on 7/16/17). LPN #5 was shown the above physician's order on Resident #8's July 2017 TAR and asked when the physician should be notified. LPN #5 stated, "I notify (physician/NP) if weight is two pounds or greater in one day. I also make a copy (of the weight) and give to him (the physician)." LPN #5 confirmed Resident #8's weight gain was greater than two pounds on 7/16/17 and stated she

Director of nursing and/or unit managers will audit residents who receive prn Ambien for documentation on medication administration sheet and the effectiveness on back of the medication administration record 5 times a week for 30 days, 3 times a week for 30 days, and 1 time a week for 30 days.

4. How will the facility monitor the corrective plan to ensure the deficient practice was corrected and do not reoccur?

Director of nursing will report finding of audits for notification and documentation to the quality assurance/performance improvement committee to review and make recommendations. Committee consist of Executive Director, Director of Nursing, Assist Director of Nursing, Social Services, Activities Director, Dietary Manager, Pharmacy consultant, Medical Director

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provided a copy of the weight to the physician. LPN #5 was asked to provide evidence of physician notification.

On 7/19/17 at 2:10 p.m. LPN #5 presented a unit ADL (activities of daily living) sheet that documented evidence that Resident #8's physician was made aware of the weight gain noted on 7/16/17. LPN #5 was asked where she should document physician notification in the clinical record. LPN #5 stated she usually documents physician notification in the computer or on the back of the TAR. LPN #5 was asked why she didn't document physician notification regarding Resident #8's weight gain on 7/16/17. LPN #5 stated, "I have no idea. I probably got side tracked."

On 7/19/17 at 5:20 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Change in a Resident's Condition" failed to document specific information regarding documentation of physician notification.

No further information was presented prior to exit.

3. The facility staff failed to document the time Ambien (used for the inability to sleep (1)) was administered to Resident #1 on the MAR (medication administartion record) and the effectiveness of the medication.

Resident #1 was admitted to the facility on 12/28/17 with a recent readmission on 5/30/17, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a

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general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), severe peripheral artery disease (any abnormal condition affecting the arteries outside the heart (2)), above the knee amputation, atrial fibrillation (a condition characterized by rapid and random contractions of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (3)), cardiac disease, aneurysm (a saclike widening in a blood vessel (4)), gastrointestinal bleed and osteoarthritis (the most common form of arthritis occurring mostly in the elderly, characterized by degenerative changes in the joints (5)).

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 5/11/17, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating he was cognitively intact to make daily decisions. Resident #1 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living, except eating in which he was coded as requiring supervision of one staff member. In Section N - Medications, the resident was coded as having received seven days of a hypnotic (sleeping pill).

The physician order dated, 5/30/17, documented, "Ambien 5 mg (milligrams) tablet, one tablet every night at bedtime PRN (as needed) insomnia, PO (by mouth) daily as needed."

The June 2017 MAR (medication administration record) documented, "Ambien 5 mg tablet, one tablet every night at bedtime PRN insomnia, PO

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daily as needed." The front of the MAR documented the medication was administered on the following dates: 6/1/17, 6/2/17, 6/3/17, 6/4/17, 6/6/17, 6/9/17, 6/12/17, 6/13/17, 6/15/17, 6/16/17, 6/17/17, 6/19/17, 6/22/17, and 6/27/17. The reverse side of the MAR only documented the date, time administered, reason for administration and effectiveness on 6/6/17 and 6/12/17.

Review of the nurse's notes for the month of June failed to evidence any documentation for the administration and effectiveness of the Ambien to Resident #1.

The July 2017 MAR documented, "Ambien 5 mg tablet, one tablet every night at bedtime PRN insomnia, PO daily as needed." The front of the MAR documented the medication was administered on the following dates: 7/1/17, 7/2/17, 7/3/17, 7/4/17, 7/5/17, 7/6/17, 7/8/17, 7/9/17, 7/10/17, 7/11/17, 7/12/17, 7/15/17, 7/16/17 and 7/17/17. There was no documentation on the reverse of the MAR regarding the administration of Ambien to Resident #1.

Review of the nurse's notes for the month of July 2017 failed to evidence any documentation of the administration and effectiveness of the Ambien to Resident #1.

An interview was conducted with LPN (licensed practical nurse) #6 on 7/19/17 at 1:42 p.m. When asked about the process for administering a PRN (as needed) medication, LPN #6 stated, "You sign it out on the MAR and document it on the Pain flow sheet." When asked about the process for non pain medications, LPN #6 stated, "You document the administration on the MAR and

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document it either on the back of the MAR or in a nurse's note, the reason and effectiveness." When asked if staff have to document the time a PRN medication was administered, LPN #6 stated, "It's not required to sign off the time as the time is recorded in the narc (narcotic) book." The current narcotic sheet was observed with LPN #6. The medication was administered between the hours of 9:00 p.m. and 9:30 p.m. for all dates documented above.

An interview was conducted with LPN #3, the unit manager, on 7/19/17 at 1:47 p.m. When asked about the process for administering a PRN medication, LPN #3 stated, "PRN medication are documented on the PRN MAR and PRN pain medication is documented on the pain flow sheet." When asked what is documented when a PRN medication is administered, LPN #3 stated, "The nurse signs it off on the front of the MAR and then on the back of the MAR they documented, the date, time, what it was given for, why and the effectiveness should be written about an hour after the administration of the medication." Resident #1's, June and July 2017 MARs and narcotic sheets were reviewed with LPN #3. When asked if the MAR should document the administration of the medication Ambien, LPN #3 stated, "Yes." When asked if the narcotic sheets are part of the resident's clinical record, LPN #3 stated, "No, they are kept in the building but they are not part of the clinical record."

The facility policy, "Administration of Medication" documented in part, "17. PRN medication is charged with initials, and time is given in the corner of the box. The following situations require an accompanying note: a. behavior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495139	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

(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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requiring use of PRN psychotropic. b. fever. c. pain. d. any situation that requires monitoring."

The executive director and director of nursing were made aware of the above findings on 7/19/17 at 5:18 p.m.

No further information was provided prior to exit.
(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012721/?report=details
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 447.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55.
(5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 34.