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 _____	07/08/2016

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
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/6/15 through 7/8/16. 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 109 at the time of the survey. The survey sample consisted of 24 current resident reviews (Residents #1 through #19 and #24 through #28) and four closed record reviews (Residents #20 through #23).	F 000	**Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.**	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157	**F157** Resident's # 3 and # 9 were identified as being affected by this practice. **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn D Kilpatrick | TITLE: Interim Executive Director | (X6) DATE: 7-30-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. 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 notify the physician of a change in resident condition for two of 28 residents in the survey sample, Residents #3 and #9. 1. The facility staff failed to notify the physician in a timely manner of bloody urine in the collection bag of Resident #3's suprapubic catheter and of his transfer to the emergency room on 6/30/16. 2. The facility staff failed to notify the physician of weight changes per the physician orders for Resident #9. The findings include: 1. Resident #3 was admitted to the facility on 2/19/15 and readmitted on 3/29/16 with diagnoses including, but not limited to: history of a stroke with one-sided paralysis, depression, enlarged prostate with obstruction, and chronic kidney disease. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 5/4/16, he was coded	F 157	F 157 Continued from Page 1 **1. Resident # 3** Resident # 3 was identified in this practice. The resident was sent to the emergency room via non-emergency transport for super pubic catheter replacement on 06/30/16, per a telephone conversation with the Urologist by facility transportation aide. Based on assessment, LPN charge nurse requested resident # 3 to be evaluated at the office but the Urologist was unavailable. The Nurse Practitioner verified that she was aware resident # 3 was being sent to ER for the catheter change on 06/30/16. Resident returned to facility same day as sent to the hospital. **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** Residents that reside in the facility have the potential to be affected by this practice.	

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F 157	Continued From page 2 as being moderately cognitively impaired for making decisions. He was coded as having a suprapubic catheter in place. On the following dates and times, Resident #3 was observed in his room, with a suprapubic catheter in place draining into a collection bag, encased in a privacy cover: 7/6/16 at 12:35 p.m. and at 3:10 p.m.; 7/7/16 at 8:10 a.m. and 2:40 p.m. During all observations, the urine in the collection bag was clear yellow. A review of the physician's orders for Resident #3 revealed the following order, written 3/29/16: "SP (suprapubic) cath (catheter) to bed side drainage for BPH (benign prostatic hyperplasia - enlarged prostate) with obs (obstructive) uropathy TID (three times a day)." A review of the nurses notes for Resident #3 revealed, in part, the following: - 6/20/16 at 5:53 p.m.: "Noted resident Foley bag and tubing with clear yellow urine." - 6/23/16 at 3:37 a.m.: "...Supra pubic catheter intact draining bloody urine..." - 6/23/16 at 10:36 p.m.: "Resident Supra Pubic catheter is intact and patent with bloody urine in bag..." - 6/24/16 at 10:02 a.m.: "Resident's catheter is noted to be leaking. Red tinged urine is noted..." - 6/27/16 at 7:52 a.m.: "Catheter continues to leak. 250 ml (milliliters) of bloody urine in catheter bag. Reported to oncoming shift." - 6/30/16 at 3:26 a.m.: "Resident cont (continued) with suprapubic catheter and noted to continue with bloody urine leaking around insertion site..." - 6/30/16 at 10:27 p.m.: "Resident returned from	F 157	F 157 Continued from Page 2 **Criterion #3 - What measures will be put in place or systematic changes made to ensure the practice will not reoccur.** Beginning on 07/25/16, education will be provided by Interim Executive Director (IED), Staff Development Coordinator (SDC) and/or Director of Nursing (DON) to licensed nurses regarding notifying the NP or Attending MD for changes in resident's condition will be completed stating the nurse must notify the attending NP or MD when any significant change occurs in a resident's physical, mental or psychological state and this notification must be documented in the medical record. This education will be completed by 08/5/16. Same education will be included in orientation for new hires. Beginning on 07/25/16, a review of documentation including 24 reports, orders and nursing/therapy documentation if applicable will be completed by the IDT team daily Monday – Friday during the Clinical IDT meeting. This review will identify residents with a change in condition and	

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F 157	Continued From page 3 ER (emergency room) at 8:30 p.m. Report from [name of nurse] at [name of local hospital] was that sp cath was replaced and x-ray to confirm placement. Urine is bloody in collection bag..." Further review of the nurses notes revealed no evidence of physician notification of the blood in the urinary collection bag or of Resident #3's transfer to the emergency room on 6/30/16. A review of the comprehensive care plan for Resident #3 dated 3/29/16 revealed, in part, the following: "Report any changes in bladder status to nurse. F/U (follow up) with urology as scheduled...Observe for and report any signs and symptoms of UTI (urinary tract infection) to physician." On 7/7/16 at 2:10 p.m., LPN (licensed practical nurse) #4 was interviewed. She regularly cares for Resident #3. When asked what should be done if she discovers blood in a urinary collection bag, she stated: "If it is a new finding, we would notify the urologist." When asked if she had ever noticed blood in Resident #3's urinary collection bag, she stated: "Most of the time, we will see blood or clots immediately after his bag gets changed. He gets his catheter changed every month in the doctor's office." When asked to verify the date of Resident #3's catheter change prior to 6/30/16, she looked in the chart. LPN #4 showed this surveyor a consultant report for Resident #3 dated 6/17/16. The report documented: "20 Fr (French - denotes catheter size) SP (supra pubic) tube changed. F/u (follow up) in 1 month for same." When shown the nurses notes as indicated above and asked about the notes on 6/20/16 describing "clear yellow urine" and 6/23/16 describing "bloody urine," LPN	F 157	F 157 Continued from Page 3 areas of follow-up needed. For identified residents, Unit managers (UM) and/or DON will complete a change in condition audit form, which includes physician notification verification. Change of condition audits will be completed 5 days a week for 3 months. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of Change in Condition audits will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the Director of Nursing (DON) or Unit Managers (UM) for 3 months or until 100% compliance is achieved.	08/05/16

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F 157	Continued From page 4 #4 stated: "That would be a new finding on the 23rd. The nurse practitioner or the doctor or the urologist should have been notified." She stated Resident #3's catheter regularly leaked at the insertion site because it was not possible to use a larger catheter size for him. She stated the urologist was aware that the resident's catheter regularly leaked at the insertion site. When asked if she could find evidence that the physician had been notified of Resident #3's transfer to the emergency room on 6/30/16, she stated: "I don't know. There's nothing here to tell what happened. That nurse is on vacation this week. I would have written a note. And I know I should have let the doctor know about the bloody urine in the bag. I just didn't." On 7/7/16 at 2:45 p.m., LPN #2, a unit manager, was interviewed. When shown the above referenced nurses notes, LPN #2 stated the physician should have been notified of the bloody urine when it first appeared on 6/23/16. She also stated she could not find evidence of assessment/documentation regarding the transfer to the emergency room on 6/30/16. She stated: "The doctor should have been made aware of all of that." On 7/7/16 at 5:30 p.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 entitled "Catheter Irrigation" revealed, in part, the following: "To provide for and maintain constant urinary drainage and to administer medication...Routine Observations: a. Changes in the resident's condition, e.g. swelling, discomfort, change in	F 157		

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F 157	Continued From page 5 output, amount, color, any sediment..." A review of the facility policy entitled "Changes in Resident's Condition or Status" revealed, in part, the following: "Nursing services will be responsible for notifying the resident's attending physician when:...There is significant change in the resident's physical, mental or emotional status...A decision has been made to transfer or discharge the resident from the facility...All changes in the resident's medical condition must be properly recorded in the resident's medical record in accordance with our documentation policies and procedures." No further information was provided prior to exit. (1) "A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem." This information is taken from the website <https://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000145.htm>. According to Basic Nursing, Essential 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	F 157		

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F 157	Continued From page 6 of a patient. 2. The facility staff failed to notify the physician of weight changes per the physician orders for Resident #9. Resident #9 was admitted to the facility on 3/3/12 with diagnoses that included but were not limited to: pneumonia, high blood pressure, low back pain, dementia, pain, hypothyroid disease, and dysphagia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/14/16, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. Resident #9 was coded as requiring limited assistance of one staff member for eating. The physician orders dated, 5/1/16, documented, "Daily weight if gains 2lbs (pounds) or more in a day or 4 lb. or more in a week, notify MD (medical doctor) daily." Review of the TAR (treatment administration record) for June 2016 documented the following weights: "6/2/16 - 116.8 6/3/16 - 120.1 (a gain of 3.3.lbs) 6/4/16 - 122.2 (a gain of 2.2 lbs.) 6/7/16 - 109.9 6/8/16 - 121.0 (a gain of 11.1 lbs.) 6/15/16 - 120.9 6/16/16 - 123.0 (a gain of 2.1 lbs.)"	F 157	**F157** **2.) Resident # 9** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident # 9 was indicated in this practice. On 07/08/16, the order for daily weights for resident # 9 was reviewed with the Nurse Practitioner (NP) and the daily weight order was discontinued. A new order was written as follows: "obtain weekly weight on Monday and notify MD or NP if weight gain exceeds 4 pounds". Interim Executive Director (IED) confirmed on 07/08/16 with NP that she was aware of fluctuations in resident #9's weight and no concerns were identified. **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** Residents with orders containing notification parameters have the potential to be affected by this practice.	

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F 157	Continued From page 7 Review of the nurse's notes and the reverse of the TAR did not reveal any documentation of the notification of the above weight gains to physician or nurse practitioner. Review of the TAR for May 2016 documented the following weights: "5/3/16 - 118.3 5/4/16 - 120.6 (a gain of 2.3 lbs.)" Review of the nurse's notes and the reverse of the TAR did not reveal any documentation of the notification of the weight gain above to the physician or nurse practitioner. The comprehensive care plan dated, 12/8/15 and updated on 3/10/16, documented, "Problems: Resident is at risk for alteration in fluid balance related to Hx (history) of UTI (urinary tract infection), Hx of recurrent hyponatremia (lower than normal concentration of sodium [salt] in the blood) (1)" The "Approaches" documented in part, "Weight as per protocol. Notify MD/NP (nurse practitioner) and family of significant change PRN (as needed)." An interview was conducted with LPN (licensed practical nurse) #4 on 7/7/16 at 12:36 p.m. LPN #4 was asked to review the above physician's order. When asked what the nurse is to do with the order, LPN #4 stated, "If they have daily weights, you check the weight. Look at the previous day and notify (name of doctor) or (name of NP) if it's above 2 pounds." An interview was conducted with LPN #3, the unit manager; on 7/7/16 at 1:00 p.m. LPN #3 was asked to review the above physician's order. When asked what the nurse is to do with that	F 157	F 157 Continued from Page 7 An audit was completed by Unit Managers (UM) on 07/25/16 to compile a list of residents with orders that contain physician notification parameters for physician orders written in the last 60 days, with an emphasis on weight gain notification parameters. Beginning on 07/28/16, the Director of Nursing (DON) reviewed the Treatment Administration Record (TAR) of residents with orders containing physician notification parameters for June and July 2016 to identify any other occurrences of missing required notifications. The audit was completed on 07/29/16 and identified concerns were compiled on a list, reviewed by the Medical Director and no new orders were received. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** Education starting on 07/26/16 provided by Interim Executive Director (IED), Staff Development Coordinator (SDC) and/or DON to Licensed Nurses regarding proper documentation of physician notification related to weights	

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F 157	Continued From page 8 order, LPN #3 stated, "You weigh the resident daily. You compare the weight to the previous day and notify the doctor or (name of NP) as ordered." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 7/7/16 at 1:08 p.m. The above physician's order was reviewed with ASM #2. When asked what the nurse is expected to do, ASM #2 stated, "You check the weight daily. You document it. Look at the previous day's weight and before. You notify the doctor or NP if there is a reason." The executive director (administrator) ASM #1 and ASM #2 were made aware of the above findings on 7/7/16. A policy on notification was requested. No further information was received prior to exit. (1) Barron's Dictionary of Medical Terms for the Non - Medical Reader, Rothenberg and Chapman, page 285	F 157	F 157 Continued from Page 8 changes when orders have set parameters. This education will be completed by 08/05/16 and the same education will be included in orientation for new hires Being on 07/25/16, the DON (Director of Nursing) or Unit Manager (UM) will audit the Treatment Administration Record (TAR) 5 days a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks to ensure physician notification occurred as indicated per physician order. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audits for documentation of physician notifications for weight changes per parameters will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON or UM for 3 months or until 100% compliance is achieved.	08/05/16
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 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 wheelchair in good repair for one of 28	F 253	**F253** **Criterion #1 - How will the corrective action be accomplished for those**	

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F 253	Continued From page 9 residents in the survey sample, Resident #6. A torn area approximately four inches long by one inch wide was observed on the back of Resident #6's wheelchair. Cloth and hard plastic were exposed. The findings include: Resident #6 was admitted to the facility on 6/26/09. Resident #6's diagnoses included but were not limited to: pain, anxiety and dementia (1). Resident #6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/6/16, coded the resident's cognition as being severely impaired. Section G documented the resident required extensive assistance of one staff with locomotion and was totally dependent on two or more staff with transfers. Resident #6's comprehensive care plan with an onset date of 1/15/15 documented, "Approaches: Provide adaptive/safety equipment such as wheelchair..." Observation of Resident #6 sitting in a specialized wheelchair with a raised back was conducted on 7/7/16 at 2:12 p.m. and 4:00 p.m. During the observations, a torn area (approximately four inches long by one inch wide) was observed on the back of Resident #6's wheelchair. Cloth and hard plastic were exposed. On 7/7/16 at 4:05 p.m., an interview was conducted with CNA (certified nursing assistant) #6 regarding wheelchair repairs. CNA #6 stated the maintenance department inspects wheelchairs for needed repairs but CNAs and nurses report concerns when seen. CNA #6 stated CNAs follow a specific schedule to clean	F 253	F253 Continued from Page 9 **residents found to have been affected by the deficient practice?** Resident # 6 was identified in this practice. On 07/07/16, the back of wheelchair for resident # 6 was repaired by the Director of Rehab (DOR) and a therapy screen was completed for appropriate wheelchair. On 07/08/16, resident # 6's wheelchair was replaced. **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All residents with wheelchairs have the potential to be affected by this practice. Beginning on 07/07/16, a 100% audit of all resident wheelchairs in use was started by the DON and Nurse Managers. The audit was completed on 07/25/16. All issues identified	

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F 253	Continued From page 10 and inspect wheelchairs. At this time, CNA #6 was shown the torn area on Resident #6's wheelchair. CNA #6 stated she had noticed the area before and the area should have been reported to the maintenance department. Review of the wheelchair cleaning schedule revealed Resident #6's wheelchair was scheduled to be cleaned during the 3:00 p.m. to 11:00 p.m. shift on Fridays. On 7/7/16 at approximately 4:30 p.m., an interview was conducted with OSM (other staff member) #3 (the maintenance assistant). OSM #3 stated torn areas on wheelchairs are repaired if the maintenance department receives a work order to repair the wheelchair or if someone from the maintenance department observes the torn area. OSM #3 stated the housekeeping department cleans wheelchairs once a year and a lot of repairs are made then. At this time, OSM #3 was made aware of the observation of the torn area on Resident #6's wheelchair at this time. OSM #6 stated, "I don't remember anything like that." On 7/7/16 at 5:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility policy titled, "Wheelchair Inspection and Maintenance" documented, "Standard: To ensure operational reliability of all wheelchairs by following the prescribed preventative maintenance program. Policy: To ensure that all wheelchairs used in this facility are inspected upon arrival to the facility. Quarterly cleaning and inspection of all chairs will be scheduled for proper operations thereafter. Procedure: 1. All	F 253	F253 Continued from Page 10 regarding wheelchair maintenance were written up on a maintenance slip with detailed report and provided to maintenance department. Identified repairs needed to wheelchairs will be completed by 08/05/16. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur?** Education starting on 07/25/16 was provided by IED, SDC, and/or DON to all Licensed Nurses, C.N.A's, housekeeping and maintenance staff regarding correct procedure for reporting identified repairs needed to wheelchairs. Education will be completed by 08/05/16 and same education will be included in orientation for new hires. Starting on 07/25/16 , the Maintenance Director or Maintenance assistant will audit 2 resident rooms daily Monday through Friday for 4 weeks, monthly for 2 months then quarterly thereafter to ensure resident equipment is in good repair.	

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F 253	Continued From page 11 new wheelchairs will be inspected by rehab (rehabilitation) services or the maintenance department upon arrival to the facility. 2. Quarterly inspection and cleaning will be scheduled for all chairs by the in-house maintenance department. 3. Chairs which are found to have broken or missing parts or are in need of repair will be taken out of use immediately and reported to the maintenance department or rehab services for repair. 4. Needed repairs will be made and / or parts ordered for all broken chairs. Wheelchair Inspections...4. Seat bottoms and seat backs are not overly worn, torn, or otherwise in need of repair." (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating..." This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html	F 253	F53 Continued from Page 11 **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of weekly and monthly audits for wheelchair maintenance will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the Interim Executive Director (IED) or Maintenance Director for 3 months or until 100% compliance is achieved. Ongoing quarterly audit results will also be presented to QA/PI committee quarterly.	08/05/16
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278	**F278** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident's # 6, #12, #10, #3 and # 8 were identified to be affected by this practice.	

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F 278	Continued From page 12 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. 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 maintain an accurate MDS (minimum data set) for 5 of 28 residents in the survey sample, Residents #6, #12, #10, #3 and #8. 1. The facility staff miscoded Section V0200 of Resident #6's annual MDS (minimum data set) with an assessment reference date of 7/15/15. The coding indicated that a dental care plan would be developed, when the staff had determined that a dental care plan would not be developed. 2. Resident # 12's annual MDS (minimum data set) assessment with an ARD of 6/15/16 was incorrectly coded in Section V for "Dental Care" under column "B" as being: "Addressed in Care	F 278	F278 Continued from Page 12 • Resident #6 was identified as affected by this practice. Section V0200 on Resident # 6's annual MDS with an ARD of 07/15/15 was corrected and MDS submitted on 07/25/16 to reflect there is not a check beside the Care Planning Decision area for the dental care area in section V20015B. • Resident #12 was identified as affected by this practice. Section V0200 on Resident # 12's annual MDS with an ARD of 06/15/16 was corrected and MDS submitted on 07/25/16 to reflect there is not a check beside the Care Planning Decision area for the dental care area in section V20015B. • Resident #10 was identified as affected by this practice. Section V0200 on Resident # 10's quarterly MDS with an ARD of 04/13/16 was corrected and MDS submitted on 07/25/16 to reflect there is not a check beside the Care Planning Decision area for the dental care area in section V20015B.	

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F 278	Continued From page 13 Plan." 3. Resident # 10's MDS (minimum data set) was incorrectly coded in Section V under column "B" as being: "Addressed in Care Plan." The coding indicated that a dental care plan would be developed, when the staff had determined that a dental care plan would not be developed. 4. The facility staff miscoded Section V020015B "Care Planning Decision" of Resident #3's annual MDS with assessment reference date 8/5/15. The coding indicated that a dental care plan would be developed, when the staff had determined that a dental care plan would not be developed. 5. The facility staff miscoded Section V020015B "Care Planning Decision" of Resident #8's annual MDS with assessment reference date 6/10/16. The coding indicated that a dental care plan would be developed, when the staff had determined that a dental care plan would not be developed. The findings include: 1. The facility staff miscoded Section V0200 of Resident #6's annual MDS (minimum data set) with an assessment reference date of 7/15/15. The coding indicated that a dental care plan would be developed, when the staff had determined that a dental care plan would not be developed. Resident #6 was admitted to the facility on 6/26/09. Resident #6's diagnoses included but were not limited to: pain, anxiety and dementia	F 278	F278 Continued from Page 13 • Resident #3 was identified as affected by this practice. Section V0200 on Resident # 3's annual MDS with an ARD of 08/05/15 was corrected and MDS submitted on 07/25/16 to reflect there is not a check beside the Care Planning Decision area for the dental care area in section V20015B. • Resident #8 was identified as affected by this practice. Section V0200 on Resident # 8's annual MDS with an ARD of 06/10/16 was corrected and MDS submitted on 07/25/16 to reflect there is not a check beside the Care Planning Decision area for the dental care area in section V20015B. **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All Residents have the potential to be affected by the practice regarding checking Column B in section V0200.	

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F 278	Continued From page 14 (1). Resident #6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/6/16, coded the resident's cognition as being severely impaired. Section V0200 of Resident #6's annual MDS with an ARD of 7/15/15 documented, "V0200. CAAs (care area assessments) and Care Planning: 1. Check column A if Care Area is triggered. 2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (resident assessment instrument) (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan..." A check mark was documented in section V020015A "Care Area Triggered" and V020015B "Care Planning Decision" for the dental care area. Review of Resident #6's comprehensive care plan with an onset date of 1/15/15 failed to reveal documentation regarding dental care. On 7/7/16 at 1:35 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (an MDS coordinator). LPN #1 stated the MDS assessment generates the care area triggers for section V. LPN #1 stated the MDS coordinators review the resident's chart and compares the MDS to the resident's current diagnoses, status and level of functioning. LPN #1 stated the decision to care plan the triggered area of dental care depends on each individual resident. LPN #1 stated a check mark documented in section V020015B (the care planning decision column for the dental care area) didn't necessarily mean the dental care area was care planned. LPN #1	F 278	F278 Continued from Page 14 **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** Education, reviewed and approved by Division Clinical Reimbursement Specialist, will be provided to all MDS coordinators and Social Services staff by RN MDS Coordinator on proper coding of column B in section V0200 per the RAI manual. Education will be completed by 08/05/16. Starting on 07/25/16, MDS nurses will provide the Director of Nursing (DON) a printed copy of section V for each MDS completed for 3 months. The DON will audit this information and confirm that care plans are developed for all concern areas identified by checkmarks in column B and if a care plan is not needed, that column B is not checked.	

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F 278	Continued From page 15 stated the check mark indicated the MDS coordinators created a care area worksheet and made a decision whether or not to care plan the dental care area. LPN #1 stated the MDS coordinators reference the RAI manual when completing MDS assessments. At this time, LPN #1 was asked to provide the corresponding dental CAA worksheet for Resident #6's annual MDS with an ARD of 7/15/15. The corresponding CAA worksheet for the dental care area documented, "Care Plan Y/N (yes/no): No. Care Plan Considerations: Oral status stable. No current issues noted." The CMS (Centers for Medicare and Medicaid Services) RAI manual documented the following: "Coding Instructions for V0200A, CAAs ·Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A 'Care Area Triggered' in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation. ·For each triggered care area, Column B 'Care Planning Decision' is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The 'Care Planning Decision' column	F 278	F278 Continued from Page 15 **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of DON's audit for correct coding of Column B in section V0200 will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the RN MDS coordinator or Director of Nursing (DON) for 3 months or until 100% compliance is achieved.	08/05/16

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F 278	Continued From page 16 must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed..." On 7/7/16 at 5:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating..." This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html 2. Resident # 12's annual MDS (minimum data set) assessment with an ARD of 6/15/16 was incorrectly coded in Section V for "Dental Care" under column "B" as being: "Addressed in Care Plan." Resident # 12 was admitted to the facility on 6/20/14 and most recently readmitted on 7/17/15 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease, congestive heart failure, hypertension, hyperlipidemia, hypothyroidism, atrial fibrillation, congestive heart failure, and bi-polar disorder *. *Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels.	F 278		

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F 278	Continued From page 17 www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml Resident # 12's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/15/16, coded Resident # 12 as understood by others and able to understand others. Resident # 12 was coded as scoring 15 of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was cognitively intact. A review of "Section V: CAA" of Resident # 12's annual MDS assessment with an ARD of 6/15/16 revealed that "# 15 Dental Care" was checked under column "A" and under column "B" was documented as: "Addressed in Care Plan." Resident # 12's most recent comprehensive care plan with a revision date of 7/1/16 failed to evidence any documentation addressing dental care. During an interview on 7/7/16 at 1:35 p.m. with LPN (licensed practical nurse) # 1, an MDS coordinator, LPN # 1 revealed that the process is that the MDS software identifies the trigger and then the staff reviews the Resident's chart to review the status of the Resident. When LPN # 1 was asked about Dental Care being triggered, LPN # 1 stated that it (whether to do the care plan) depends on each Resident. LPN # 1 reviewed Resident # 12's MDS and agreed that under column B was documented: "Addressed in Care Plan." LPN # 1 was asked what it means if "B. Care Planning Decision" is checked and LPN # 1 stated that what they do is look at the	F 278		

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F 278	Continued From page 18 worksheet and then decide if they will do a care plan or not. When asked what resource they use for completing the MDS assessments LPN # 1 stated she used the RAI (Resident Assessment Instrument) manual. During an interview on 7/7/16 at 2:55 p.m. with RN (registered nurse) # 2, an MDS coordinator, RN # 2 was shown Resident # 12's MDS for Dental Care and asked what it meant if "B. Care Planning Decision" was checked. RN # 2 stated that if that is checked then they must go and evaluate the Resident and decide whether to do a care plan. RN # 2 provided a copy of the CAA worksheet # 15 DENTAL CARE; this worksheet documented that Resident # 12's record was reviewed and that the MDS staff decided to not care plan dental care. RN # 2 was asked what reference she uses to complete the MDA Assessments and RN # 2 stated that she uses the RAI manual. At this time RN # 2 was asked if she could provide and copy of the instructions from the RAI manual. During the end of day interview on 7/7/16 at 5:30 p.m. with ASM (administrative staff member) # 1, executive director, and ASM # 2, director of nurses, they were made aware of the MDS issue. During an interview on 7/8/16 at 8:32 a.m. with ASM # 2, ASM # 2 stated, "I presented everything I have." No further information was provided prior to exit. 3. Resident # 10's MDS (minimum data set) was incorrectly coded in Section V under column "B" as being: "Addressed in Care Plan." The coding indicated that a dental care plan would be	F 278		

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F 278	Continued From page 19 developed, when the staff had determined that a dental care plan would not be developed. Resident #10 was admitted to the facility on 1/8/16 with diagnoses that included but were not limited to: arthritis, dementia, high blood pressure, kidney disease and diabetes. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 4/13/16 coded the resident as having a six out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring the assistance of staff for all activities of daily living. In section L 0200 the resident was coded as having no teeth. Section V0200 of Resident #10 ' s admission MDS with an ARD of 1/8/16 documented, "V0200. CAAs (care area assessments) and Care Planning: 1. Check column A if Care Area is triggered. 2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (resident assessment instrument) (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan..." A check mark was documented in section V020015A "Care Area Triggered" and V020015B "Care Planning Decision" for the dental care area. Review of the comprehensive care plan initiated on 1/8/16 did not evidence documentation of a dental plan of care.	F 278		

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F 278	Continued From page 20 An interview was conducted on 7/7/16 at 1:35 p.m. with LPN (licensed practical nurse) #1, the MDS coordinator. When asked who completed section L of the MDS, LPN #1 stated that the MDS coordinators did. When asked the process for care planning, LPN #1 stated, "Basically the MDS (coordinators) pulls the triggers (from the CAA form), pull the chart, review the current status according to the RAI (resident assessment instrument) manual and proceed to the care plan." When asked what the check mark in the box titled care plan on the CAA meant, LPN #1 stated, "The check mark means we have made a decision on the CAA worksheet." LPN #1 stated that the resident's dental status was stable and did not require a care plan. When asked why the CAA documented that a dental care plan was to be developed, LPN #1 stated, "That means we are going to review it, not that we would care plan it." Review of the facility's policy titled, "Resident Care Plan", documented, "The individualized interdisciplinary care plan is to be completed by participation of all disciplines and printed within 7 days of the RAI completion, according to RAI guidelines." On 7/7/16 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 4. The facility staff miscoded Section V020015B "Care Planning Decision" of Resident #3's annual MDS with assessment reference date 8/5/15.	F 278		

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F 278	Continued From page 21 The coding indicated that a dental care plan would be developed, when the staff had determined that a dental care plan would not be developed. Resident #3 was admitted to the facility on 2/19/15 and readmitted on 3/29/16 with diagnoses including, but not limited to: history of a stroke with one-sided paralysis, depression, enlarged prostate with obstruction, and chronic kidney disease. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date, he was coded as being moderately cognitively impaired for making decisions. A review of Resident ##3's annual MDS with an assessment reference date 8/5/15 revealed a check mark in the box for section V020015B "Care Planning Decision". According to the directions on the MDS, "Check column B if the triggered care area is addressed in the care plan." A review of Resident #3's comprehensive care plan dated 8/9/15 revealed no evidence of a dental care plan. On 7/7/16 at 1:30 p.m., LPN (licensed practical nurse) #1 confirmed that Resident #3 did not have a dental care plan. She stated that according to the CAA (care area assessment) worksheets dated 8/5/15, the facility staff did not intend to develop a care plan due to Resident #3 being without teeth. No further information was provided prior to exit.	F 278		

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F 278	Continued From page 22 5. The facility staff miscoded Section V020015B "Care Planning Decision" of Resident #8's annual MDS with assessment reference date 6/10/16. The coding indicated that a dental care plan would be developed, when the staff had determined that a dental care plan would not be developed. Resident #8 was admitted to the facility on 6/27/13 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, chronic back pain and anxiety disorder. On the most recent MDS (minimum data set), an annual assessment dated 6/10/16, Resident #8 was coded as being cognitively intact for making daily decisions. Further review of the 6/10/16 annual assessment revealed a check mark in the box for section V020015B "Care Planning Decision". According to the directions on the MDS, "Check column B if the triggered care area is addressed in the care plan." A review of Resident #8's comprehensive care plan dated 3/23/15 revealed no evidence of a dental care plan. On 7/7/16 at 1:30 p.m., LPN (licensed practical nurse) #1 confirmed that Resident #8 did not have a dental care plan. She stated that according to the CAA (care area assessment) worksheets dated 8/5/15, the facility staff did not intend to develop a care plan due to Resident #8 being without teeth. No further information was provided prior to exit.	F 278		

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F 280	Continued From page 23	F 280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. 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 28 residents in the survey sample, Residents #27 and #7. 1. The facility staff failed to review and revise the comprehensive care plan for Resident #27 after she had a physical altercation with another resident on 6/14/16. 2. The facility staff failed to review and revise the	F 280	**F280** **1.) - Resident # 27** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident # 27 was identified in this practice. The care plan for resident # 27 was reviewed and revised on 07/07/16 by the DON, Social Services Director (SSD) and the LPN Unit Manager (UM) to reflect resident's behaviors on 06/14/16.	

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F 280	Continued From page 24 comprehensive care plan for a change in Resident #7's diet requirements. The findings include: 1. The facility staff failed to review and revise the comprehensive care plan for Resident #27 after she had a physical altercation with another resident on 6/14/16. Resident #27 was admitted to the facility on 8/19/14 and most recently readmitted on 10/14/15 with diagnoses including, but not limited to: Alzheimer's disease, coronary artery disease, and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 5/18/16, Resident #27 was coded as being severely cognitively impaired for making daily decisions, having scored six out of 15 on the BIMS (brief interview for mental status). She was coded as not having demonstrated any behaviors directed toward others during the look back period. A review of the nurses' notes for Resident #27 revealed a note written 6/14/16 at 3:14 p.m.: "At approximately 1:30 p.m., resident was noted to be wheeling herself in her wheelchair up the [sic] hallway when she ran into another resident. Resident stated to her, 'I wish you would watch were you are going. I know you can see me.' She then smacked [Resident #27] in the right forearm. Resident has no s/s of bruising to that area. Resident will be monitored for any discoloration to that area. Resident did not become visibly upset over this altercation. Will continue to monitor." The nurse who wrote this note was not available for interview during the survey.	F 280	F280 Continued from Page 24 **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All residents who reside in the facility have the potential to be affected by this practice. On 07/25/16, the Social Services Director, Unit Manager, DON completed an 100% audit of all resident care plans to ensure any resident to resident altercations within the past 3 months were appropriately updated on behavioral care plans. Care Plans have been revised to reflect any concerns identified. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** Beginning on 07/25/16, the IED, SDC and/or DON will provide education to all licensed nurses and social service staff related to review and revision of care plans after any incident, including resident to resident altercations. This education will be completed by 08/05/16.	

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F 280	Continued From page 25 A review of the care plan dated 4/15/16 revealed no information regarding this altercation. On 7/8/16 at 9:10 a.m., LPN #4 was interviewed. When asked what should be done when two residents are involved in an altercation with each other, she stated she would split the residents up and keep them away from each other for as long as possible. When asked how other staff members would know to keep these residents apart, she stated: "Everyone knows who to look out for. Everybody knows everybody up here." She stated she would fill out an incident report, and tag both residents for "alert charting." She stated this was the facility's process for close monitoring of residents for any reason. She stated alert charting happens for three days on every shift following any sort of major event or change. When asked if the care plan should be updated, she stated: "We normally don't update the care plan. We notify the doctor or the family. But it is understood. Everyone knows which residents to keep apart." On 7/8/16 at 11:00 a.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. ASM #2 stated she would review Resident #27's care plan again to make sure there were no updates. She stated the care plan should have been updated with this incident. A review of the facility policy entitled "Resident Care Plan" revealed, in part, the following: "Review of the care plan is done at least quarterly and as needed to reflect the resident's current needs, problems, goals, care, treatment and services."	F 280	F280 Continued from Page 25 The DON, Unit Managers (UM) and/or Social Services will audit orders, incident reports and 24 hour reports daily Monday through Friday during the clinical IDT meeting to ensure care plans are reviewed and revised as needed. Audits will be completed daily, Monday through Friday for 3 months. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audits for care plans being updated after all incidents will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the MDS coordinator, Director of Nursing (DON) or Unit Manager (UM) for 3 months or until 100% compliance is achieved.	08/05/16

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F 280	Continued From page 26 No further information was provided prior to exit. Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." 2. The facility staff failed to review and revise the comprehensive care plan for a change in Resident #7's diet requirements. Resident #7 was admitted to the facility on 6/8/15 with diagnoses that included but were not limited to: anxiety, dysuria, high blood pressure, pain, dementia, edema, hypothyroid disease, depression, and osteoporosis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/13/16, coded the resident as being severely impaired to make cognitive 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 limited assistance of one staff member.	F 280	F280 Continued from Page 26 **F280** **2.) Resident #7** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident # 7 was identified as being affected in this practice. The nutritional care plan for resident # 7 was reviewed and revised on 07/07/16 by the Director of Nursing (DON), Food Services Director (FSD) and the LPN Unit Manager to reflect correct diet.	

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F 280	Continued From page 27 The "Physician Orders July 2016" documented, "DIET: Regular." This order was dated 10/14/15. The orders were signed by the physician on 6/29/16. Review of the care plan dated, 6/8/15 and reviewed on 5/23/16, documented in part, "Problems: Resident is at nutrition risk, evidenced by abnormal labs (laboratory test results), weight fluctuation, leaves 25 % or more of food uneaten for most meals, chewing problem, swallowing problem." A dietary communication form dated 10/10/15, documented, "Please change diet to thin (liquids) and dysphagia (diet texture)." An interview was conducted with LPN (licensed practical nurse) #2, the unit manager, on 7/7/16 at 9:58 a.m. When asked if Resident #7 was on thickened liquids, LPN #2 stated, "No, why are you asking that?" When asked who is responsible for updating the care plans, LPN #2 stated, "Nursing." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 7/7/16 at 12:33 p.m. When asked who is responsible for updating the care plans, ASM #2 stated, "The floor nurses, MDS, unit managers, basically all nurses." When asked if the care plan should be up to date, ASM #2 stated, "Yes." The above was shared with ASM #2 at this time. The facility policy, "Resident Care Plan" documented in part, "Review of the care plan is done at least quarterly and as needed to reflect the resident's current needs, problems, goals, care, treatment and services."	F 280	F280 Continued from Page 27 **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All residents who reside in the facility have the potential to be affected by this practice. On 07/25/16, the Unit Managers, DON and/or Food Service Director completed an 100% audit of all resident nutrition care plans to ensure all diets are correct and any changes within the past 3 months were appropriated updated. As of 07/26/16, all nutritional care plans for residents in house have been reviewed and reflect current dietary problems and approaches. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** Beginning on 07/25/16, the IED, SDC and/or DON will provide education to licensed nurses and Food Services Director and Assistant Food Services Director related to review and revision of care plans after any dietary communication slips or order change. This education will be completed by 08/05/16.	

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F 280	Continued From page 28 According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." The executive director and ASM #2 were made aware of the above findings on 7/7/16 at 5:28 p.m.	F 280	F280 Continued from Page 28 The DON, Unit Managers and/or Food Services Director will audit orders, 24 hour reports and dietary communication forms daily, Monday through Friday during the clinical IDT meeting to ensure care plans are reviewed and revised as needed. Audits will be completed daily, Monday through Friday for 3 months. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audits for care plans being reviewed and updated after dietary changes will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the Director of Nursing (DON), Food Service Director, or MDS Coordinator for 3 months or until 100% compliance is achieved.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. 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 follow professional standards of practice for order clarification for one of 28 residents in the survey sample, Resident #3. The facility staff failed to clarify an order to flush a suprapubic catheter to include the volume and type of flushing solution for Resident #3.	F 281	**F281** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident # 3 was identified in this	08/05/16

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F 281	Continued From page 29 The findings include: Resident #3 was admitted to the facility on 2/19/15 and readmitted on 3/29/16 with diagnoses including, but not limited to: history of a stroke with one-sided paralysis, depression, enlarged prostate with obstruction, and chronic kidney disease. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date, 5/4/16, Resident #3 was coded as being moderately cognitively impaired for making decisions. He was coded as having a suprapubic catheter in place. On the following dates and times, Resident #3 was observed in his room, and to have a suprapubic catheter draining in to a collection bag, encased in a privacy cover: 7/6/16 at 12:35 p.m. and at 3:10 p.m.; 7/7/16 at 8:10 a.m. and 2:40 p.m. During all observations, the urine in the collection bag was clear yellow. A review of the nurses' notes revealed, in part, the following: - 6/18/16 at 4:07 a.m.: "Resident noted to have blood clots and blood in urine this a.m. (morning). Reported to oncoming shift. Resident usually has blood and clots in urine after going out for catheter change." - 6/18/16 at 10:05 p.m.: "Cath (catheter) bag changed again due to a blood clot. Urine is red in color with clots. There has been no c/o (complaint of) pain or discomfort." - 6/19/16: "Cath clotting, draining mostly pure blood out. [Name of NP (nurse practitioner)] notified, given new order to flush cath X 3 (three times) q shift (each shift) and that she would follow-up tomorrow."	F 281	F281 Continued from Page 29 practice. The PRN catheter flush order dated 06/19/16 was discontinued as of 07/13/16. A new PRN catheter flush order was written on 07/13/16 which contained clarified orders regarding frequency, volume and type of flushing solution. **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All residents residing in the facility have the potential to be affected by this practice. On 07/13/16, a LPN Unit Manager completed a 100% audit of all catheter flush orders written in the last 30 days and reviewed Urinary Catheter care plans for residents identified with catheters. All orders were complete and care plans up to date. No other issues related to flush orders were identified. Beginning on 07/25/16, the Director of Nursing (DON) and/or Licensed Charge Nurse reviewed all physician orders to ensure orders were complete. For any orders identified as not complete, a licensed nurse notified the Physician for clarification. This review will be completed by 08/01/2016.	

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F 281	Continued From page 30 A review of the physician's orders for Resident #3 revealed the following order, written 3/29/16: "SP (suprapubic) cath (catheter) to bed side drainage for BPH (benign prostatic hyperplasia - enlarged prostate) with obs (obstructive) uropathy TID (three times a day)." The review also revealed the following order, written 6/19/16 by the nurse practitioner: "Flush cath X 3 (three times) q shift (every shift) due to clots. [Name of nurse practitioner] will follow up in am (morning)." A review of the TAR (treatment administration record) for Resident #3 for June 2016 revealed that his suprapubic catheter was flushed as ordered on 6/19/16, 6/20/16 and 6/21/16. A review of the comprehensive care plan for Resident #3 dated 3/29/16 revealed, in part, the following: "F/U (follow up) with urology as scheduled. Irrigate Foley per order. If unable to irrigate, notify urology." On 7/7/16 at 2:10 p.m., LPN (licensed practical nurse) #4 who regularly cares for Resident #3, was interviewed. LPN #4 was asked to review the order and the TAR referenced above (which contained her initials) for flushing Resident #3's catheter. She was asked what kind of solution she used to flush the catheter, and how much of the solution she used. LPN #4 stated: "I couldn't say. The order doesn't say. I probably did about 40 mls (milliliters), but I don't know. I am sure I used normal saline." When asked if the order should have specified the amount and type of flushing solution, LPN #4 stated: "Definitely. It should have been clarified." On 7/7/16 at 2:45 p.m., LPN #2, a unit manager,	F 281	F281 Continued from Page 30 **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** Beginning on 07/25/16, the IED, SDC and/or DON will provide education to licensed nurses, the Nurse Practitioner and the Attending Physician/Medical Director regarding specifics required for a complete Physicians order with emphasis on catheter flush orders. Catheter flush orders must include frequency, volume and type of solution to be used. The education will also include that any changes related to flushes must be updated in the resident's Urinary Catheter care plan. This education will be completed by 08/05/16. The DON and/or Unit Managers (UM) will audit orders and 24 hour reports daily, Monday through Friday during the clinical IDT meeting to ensure all orders are complete when written and/or clarified when identified by the DON or UM to not be complete. Audits will be completed daily, Monday through Friday for 3 months.	

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F 281	Continued From page 31 was interviewed. When shown the above referenced order and TAR, LPN #2 stated the nurses should have clarified the order with the nurse practitioner regarding amount and type of flushing solution. On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. On 7/8/16 at 12:30 p.m., ASM #2 was asked what professional standard of practice the facility uses for catheter irrigation. She stated that the facility uses its own policy. A review of the facility policy entitled "Catheter Irrigation" revealed, in part, the following: "To provide for and maintain constant urinary drainage and to administer medication...The plan of care must address...the type of solution, amount, and frequency of the irrigation." A review of the facility policy entitled "Physician's Orders/Transcription" revealed no information related to the required contents of the order for catheter flushing. No further information was provided prior to exit. (1) "A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem." This information is taken from the website https://www.nlm.nih.gov/medlineplus/ency/patienti	F 281	F281 Continued from Page 31 **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audits for order completeness and necessary care plan updates will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the MDS coordinator, Director of Nursing (DON) or Unit Manager (UM) for 3 months or until 100% compliance is achieved.	08/05/16

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F 281	Continued From page 32 nstructions/000145.htm. According to Fundamentals of Nursing, Potter and Perry, 6th edition, page 1362: "Assess physician's order for type of irrigation and irrigation solution to use...Prepare prescribed sterile solution in sterile graduated cup."	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review,it was determined that the facility staff failed to follow physician's orders for one of 28 residents in the survey sample, Resident #9. The facility staff failed to follow the physician order to notify the physician of a daily weight gain of two pounds or more in one day for Resident #9. The findings include: Resident #9 was admitted to the facility on 3/3/12 with diagnoses that included but were not limited to: pneumonia, high blood pressure, low back pain, dementia, pain, hypothyroid disease, and	F 309	**F309** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident # 9 was identified in this practice. On 07/08/16, the order for daily weights for resident # 9 was reviewed with the Nurse Practitioner (NP) and the daily weight order was discontinued. A new order was written as follows: "obtain weekly weight on Monday and notify MD or NP if weight gain exceeds 4 pounds". Interim Executive Director (IED) confirmed on 07/08/16 with NP that she was aware of fluctuations in resident #9's weight and no concerns were identified.	

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F 309	Continued From page 33 dysphagia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/14/16, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. Resident #9 was coded as requiring limited assistance of one staff member for eating. The physician orders dated, 5/1/16, documented, "Daily weight if gains 2lbs (pounds) or more in a day or 4 lb. or more in a week, notify MD (medical doctor) daily." Review of the TAR (treatment administration record) for June 2016 documented the following weights: "6/2/16 - 116.8 6/3/16 - 120.1 (a gain of 3.3.lbs) 6/4/16 - 122.2 (a gain of 2.2 lbs.) 6/7/16 - 109.9 6/8/16 - 121.0 (a gain of 11.1 lbs.) 6/15/16 - 120.9 6/16/16 - 123.0 (a gain of 2.1 lbs.)" Review of the nurse's notes and the reverse of the TAR did not reveal any documentation of the notification of the above weight gain to the physician or nurse practitioner. Review of the TAR for May 2016 documented the following weights: 5/3/16 - 118.3 5/4/16 - 120.6 (a gain of 2.3 lbs.)	F 309	F309 Continued from Page 33 **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** Residents with orders containing notification parameters have the potential to be affected by this practice. An audit was completed by Unit Managers (UM) on 07/25/16 to compile a list of residents with physician notification parameters with an emphasis on weight orders for all physician orders written in the last 60 days. Beginning on 07/28/16, the Director of Nursing (DON) reviewed the Treatment Administration Record (TAR) of residents with orders containing physician notification parameters for June and July 2016 to identify any other occurrences of missing required notifications. The audit was completed on 07/29/16 and identified concerns were compiled on a list, reviewed by the Medical Director and no new orders were received.	

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F 309	Continued From page 34 Review of the nurse's notes and the reverse of the TAR did not reveal any documentation of notification of the above weight gain to the physician or nurse practitioner. The comprehensive care plan dated, 12/8/15 and updated on 3/10/16, documented, "Problems: Resident is at risk for alteration in fluid balance related to Hx (history) of UTI (urinary tract infection), Hx of recurrent hyponatremia (lower than normal concentration of sodium [salt] in the blood) (1)" The "Approaches" documented in part, "Weight as per protocol. Notify MD/NP (nurse practitioner) and family of significant change PRN (as needed)." An interview was conducted with LPN (licensed practical nurse) #4 on 7/7/16 at 12:36 p.m. LPN #4 was asked to review the above physician's order. When asked what the nurse is to do with the order, LPN #4 stated, "If they have daily weights, you check the weight. Look at the previous day and notify (name of doctor) or (name of NP) if it's above 2 pounds." An interview was conducted with LPN #3, the unit manager; on 7/7/16 at 1:00 p.m. LPN #3 was asked to review the above physician's order. When asked what the nurse is to do with that order, LPN #3 stated, "You weigh the resident daily. You compare the weight to the previous day and notify the doctor or (name of NP) as ordered." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 7/7/16 at 1:08 p.m. The above physician's order was reviewed with ASM #2. When asked	F 309	F309 Continued from Page 34 **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** Beginning on 07/26/16, education will be provided by Interim Executive Director (IED), Staff Development Coordinator (SDC) and/or DON to Licensed Nurses regarding proper documentation of physician notification related to weight changes when orders have set parameters. This education will be completed by 08/05/16 and the same education will be included in orientation for new hires Beginning on 07/25/16, the DON or Unit Manager (UM) will audit the Treatment Administration Record (TAR) 5 days a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks to ensure physician notification occurred as indicated per physician order.	

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

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F 309	Continued From page 35 what the nurse is expected to do, ASM #2 stated, "You check the weight daily. You document it. Look at the previous day's weight and before. You notify the doctor or NP if there is a reason." 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 (administrator) ASM #1 and ASM #2 were made aware of the above findings on 7/7/16. A policy was requested on following physician orders at this time. No further information was received prior to exit. (1) Barron's Dictionary of Medical Terms for the Non - Medical Reader, Rothenberg and Chapman, page 285	F 309	F309 Continued from Page 35 **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audits for documentation of physician notifications per parameters will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON or UM for 3 months or until 100% compliance is achieved.	08/05/16
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. 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 restorative nursing services to prevent a resident from declining in ADL (activities of daily	F 311	**F311** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident # 4 was identified in this practice. An order to discontinue restorative dining services for resident # 4 as of 06/23/16 was written and approved by attending physician on 07/07/16. Resident is assisted with all meals by facility staff.	

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F 311	Continued From page 36 living functioning) for one of 28 residents in the survey sample, Resident #4. The facility staff failed to provide restorative nursing services as recommended by the therapy staff for Resident #4. The findings include: Resident #4 was admitted to the facility on 2/9/16 with diagnoses including, but not limited to: chronic kidney disease, diabetes, congestive heart failure and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 5/18/16), she was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of staff for bed mobility, dressing, personal hygiene and bathing. Observations of Resident #4 during the survey revealed the following: - 7/6/16 at 12:40 p.m. - Resident #4 in wheelchair beside her bed, eating lunch, attempting to feed herself. Resident #4 was slow at feeding; closed her eyes between bites four times; at 2:50 p.m. - Resident #4 was lying supine in bed with eyes closed. - 7/7/16 at 8:10 a.m. - Resident #4 seated in wheelchair beside her bed; eating breakfast, attempting to feed herself. Resident #4 was slow at feeding; closed her eyes between bites nine times; at 11:15 - Resident #4 was lying supine in bed with eyes closed; at 2:35 - Resident #4 was lying supine in bed with eyes closed.	F 311	F311 Continued from Page 36 **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All residents on restorative case load have the potential to be affected by this practice. A 100% audit of residents with orders for restorative services, including restorative dining was performed by Unit Manager/Restorative Nurse on 07/21/16, to ensure restorative programs were documented, and care planned to reflect improvement, decline, continuation or discontinuation of restorative programs. No other issues were identified. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur?** On 07/07/16, education was provided by Unit Manager/Restorative Nurse to all Restorative Certified Nursing Assistants on proper procedures for discontinuing any type of restorative services.	

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F 311	Continued From page 37 There was no evidence of any restorative nursing services for dining being provided to Resident #4 during these observations. A review of Resident #4's clinical record revealed a document entitled "Restorative Nursing Referral" dated 6/1/16. A review of this document revealed, in part, the following: "Pt (patient) would benefit from restorative assistance to improve attention to task while eating and to improve meal pacing. Pt. requires max (maximum) verbal cueing to take bites after swallowing and to chew and swallow in a timely manner. Recommended Frequency 7 X (times) per week; 2X/day. Patient is tolerating a regular diet but is requiring an hour or more to complete meals. To begin Sat. (Saturday) June 4, 2016." The form was signed by LPN (licensed practical nurse) #2, the restorative nursing coordinator. A review of Resident 4's TARs (treatment administration records) revealed that the restorative services were stopped on 6/22/16, and that Resident #4 had not received restorative services since that date. A review of the nurses notes failed to reveal evidence regarding discontinuation of restorative services. A review of the comprehensive care plan dated 4/29/16 failed to reveal any information related to restorative nursing services for dining. On 7/7/16 at 3:50 p.m., LPN #3, the unit manager, was asked if Resident #4 was receiving restorative services. She stated that she would check the chart and speak with LPN #2, the restorative nursing coordinator.	F 311	F311 Continued from Page 37 Beginning on 07/25/16, the Unit Manager (UM), restorative nurse or DON will audit 100% of restorative case load weekly for 3 months to ensure restorative services are being completed per physician orders. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audits for documentation of restorative services per physician orders will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON, Restorative Nurse or Unit Manager (UM) for 3 months or until 100% compliance is achieved.	08/05/16

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F 311	Continued From page 38 On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. On 7/8/16 at 10:45 a.m., LPN #2 was interviewed. LPN #2 stated that she was not working during the week of 7/22/16 when the restorative services for Resident #4 were discontinued. LPN #2 stated that she was told that Resident #4 had achieved maximum benefit from the services. She stated when she returned from her vacation, she instructed her staff members that they needed an order to discontinue the services, and that documentation needed to be gathered and verified before restorative services could stop. A review of the facility policy entitled "Restorative Dining Overview" revealed, in part, the following: "Establish goals to be achieved by the resident through the program and include the information for care planning. Assure that the resident is assisted by the assigned restorative aide at each meal...Periodic assessment of any progress, offering the opportunity to reassess and modify the program to further enhance the resident's quality of life. Establish an individual maintenance program after the resident has reached their highest level of functioning. Continue to monitor the resident for signs of regression and continue to document for the maintenance program." No further information was provided prior to exit.	F 311		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315	**F315** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?**	

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F 315	Continued From page 39 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder 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 provide care and services for a suprapubic catheter (1) for one of 28 residents in the survey sample, Resident #3. The facility staff failed to notify the physician in a timely manner of bloody urine in the collection bag of Resident #3's suprapubic catheter. On 6/30/16, the facility staff transferred Resident #3 to the emergency room to have the suprapubic catheter replaced, but failed to document assessment(s) of the suprapubic catheter and events leading to the transfer of Resident #3 to the emergency room. The findings include: Resident #3 was admitted to the facility on 2/19/15 and readmitted on 3/29/16 with diagnoses including, but not limited to: history of a stroke with one-sided paralysis, depression, enlarged prostate with obstruction, and chronic kidney disease. On the most recent MDS	F 315	F315 Continued from Page 39 Resident # 3 was identified in this practice. On 06/30/16, based on assessment, LPN charge nurse requested resident # 3 to be evaluated by his Urologist. When contacted for an appointment, the Urologist was not available for an office visit and instruction was received from the Urologist's office to send resident #3 to the emergency room via non-emergency transport for super pubic catheter replacement. The Nurse Practitioner verified that she was aware resident # 3 was being sent to ER for the catheter change on 06/30/16. Resident returned to facility from the hospital same day. **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All residents with catheters have the potential to be affected by this practice. On 07/25/16, LPN Unit Managers and/or DON completed a 100% audit of all nurse's notes, Urinary Catheter Care Plans and orders for the last 60 days for residents identified with catheters. No other issues were identified.	

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F 315	Continued From page 40 (minimum data set), a quarterly assessment with assessment reference date, he was coded as being moderately cognitively impaired for making decisions. He was coded as having a suprapubic catheter in place. On the following dates and times, Resident #3 was observed in his room, and to have a suprapubic catheter draining in to a collection bag, encased in a privacy cover: 7/6/16 at 12:35 p.m. and at 3:10 p.m.; 7/7/16 at 8:10 a.m. and 2:40 p.m. At all observations, the urine in the collection bag was clear yellow. A review of the physician's orders for Resident #3 revealed the following order, written 3/29/16: "SP (suprapubic) cath (catheter) to bed side drainage for BPH (benign prostatic hyperplasia - enlarged prostate) with obs (obstructive) uropathy TID (three times a day)." A review of the nurses notes for Resident #3 revealed, in part, the following: - 6/20/16 at 5:53 p.m.: "Noted resident Foley bag and tubing with clear yellow urine." - 6/23/16 at 3:37 a.m.: "...Supra pubic catheter intact draining bloody urine..." - 6/23/16 at 10:36 p.m.: "Resident Supra Pubic catheter is intact and patent with bloody urine in bag..." - 6/24/16 at 10:02 a.m.: "Resident's catheter is noted to be leaking. Red tinged urine is noted..." - 6/27/16 at 7:52 a.m.: "Catheter continues to leak. 250 ml (milliliters) of bloody urine in catheter bag. Reported to oncoming shift." - 6/30/16 at 3:26 a.m.: "Resident cont (continued) with suprapubic catheter and noted to continue with bloody urine leaking around	F 315	F315 Continued from Page 40 **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** Beginning on 07/25/16, the IED, SDC and/or DON will provide education to all licensed nurses regarding proper documentation related to a resident's change in condition, including assessments needed and documentation required when sending a resident out of the facility for unplanned evaluation and treatment. Education also includes notifying the Nurse Practitioner, Attending Physician and responsible party of resident's change of condition and proper documentation in the medical record. Education will be completed by 08/05/16. The DON and/or Unit Managers will audit orders and 24 hour reports daily Monday through Friday during the clinical IDT meeting to ensure changes in condition related to residents with catheters were properly assessed, notifications were made, care plans are updated, and orders are written. Audits will be completed daily, Monday through Friday for 3 months.	

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F 315	Continued From page 41 insertion site..." - 6/30/16 at 10:27 p.m.: "Resident returned from ER (emergency room) at 8:30 p.m. Report from [name of nurse] at [name of local hospital] was that sp cath was replaced and x-ray to confirm placement. Urine is bloody in collection bag..." Further review of the nurses notes revealed no evidence of assessment or documentation regarding Resident #3's suprapubic catheter assessment or his transfer to the emergency room on 6/30/16. A review of the comprehensive care plan for Resident #3 dated 3/29/16 revealed, in part, the following: "Report any changes in bladder status to nurse. F/U (follow up) with urology as scheduled...Observe for and report any signs and symptoms of UTI (urinary tract infection) to physician." Further review of Resident #3's clinical record revealed no evidence of a urinary tract infection in June 2016. On 7/7/16 at 2:10 p.m., LPN (licensed practical nurse) #4 was interviewed. She regularly cares for Resident #3. When asked what should be done if she discovers blood in a urinary collection bag, she stated: "If it is a new finding, we would notify the urologist." When asked if she had ever noticed blood in Resident #3's urinary collection bag, she stated: "Most of the time, we will see blood or clots immediately after his bag gets changed. He gets his catheter changed every month in the doctor's office." When asked to verify the date of Resident #3's catheter change prior to 6/30/16, she looked in the chart. She showed the surveyor consultant report for	F 315	F315 Continued from Page 41 **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audits regarding change in condition related to catheter care including proper notifications will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the Director of Nursing (DON) or Unit Manager (UM) for 3 months or until 100% compliance is achieved.	08/05/16

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F 315	Continued From page 42 Resident #3 dated 6/17/16. The report stated: "20 Fr (French - denotes catheter size) SP tube changed. F/u (follow up) in 1 month for same." When shown the nurses notes as indicated above and asked about the notes on 6/20/16 describing "clear yellow urine" and 6/23/16 describing "bloody urine," LPN #4 stated: "That would be a new finding on the 23rd. The nurse practitioner or the doctor or the urologist should have been notified." She stated Resident #3's catheter regularly leaked at the insertion site because it was not possible to use a larger catheter size for him. She stated the urologist was aware that the resident's catheter regularly leaked at the insertion site. When asked about the events leading to Resident #3's transfer to the emergency room on 6/30/16, she stated: "I don't know. There's nothing here to tell what happened. That nurse is on vacation this week. I would have written a note. And I know I should have let the doctor know about the urine in the bag. I just didn't." On 7/7/16 at 2:45 p.m., LPN #2, a unit manager, was interviewed. When shown the above referenced nurses notes, she stated the physician should have been notified of the bloody urine when it first appeared on 6/23/16. She also stated she could not find evidence of assessment/documentation regarding the transfer to the emergency room on 6/30/16. She stated: "Assessments should have been done and notes should have been written." On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns.	F 315		

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F 315	Continued From page 43 A review of the facility policy entitled "Catheter Irrigation" revealed, in part, the following: "To provide for and maintain constant urinary drainage and to administer medication...Routine Observations: a. Changes in the resident's condition, e.g. swelling, discomfort, change in output, amount, color, any sediment..." A review of the facility policy entitled "Changes in Resident's Condition or Status" revealed, in part, the following: "Nursing services will be responsible for notifying the resident's attending physician when:...There is significant change in the resident's physical, mental or emotional status...A decision has been made to transfer or discharge the resident from the facility...All changes in the resident's medical condition must be properly recorded in the resident's medical record in accordance with our documentation policies and procedures." No further information was provided prior to exit. (1) "A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem." This information is taken from the website https://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000145.htm. "Sediment, clots or the abdominal wall itself can block the suprapubic catheter. Adequate fluid intake will help to minimize risk of blockage by sediment or infection due to stagnation. The suprapubic catheter must remain patent at all	F 315		

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F 315	Continued From page 44 times. Nurses must monitor the client ' s I&O (intake and output) carefully, monitor the appearance of urine, and observe for signs of infection." This information is taken from Fundamentals of Nursing, Potter and Perry, 6th edition, page 1365.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 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 implement a physician ordered safety intervention for 1 of 28 residents in the survey sample, Resident #6. The facility staff failed to implement Resident #6's pressure chair alarm per a physician's order. The findings include: Resident #6 was admitted to the facility on 6/26/09. Resident #6's diagnoses included but were not limited to: pain, anxiety and dementia (1). Resident #6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/6/16, coded the	F 323	**F323** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident # 6 was identified as being affected by this practice. Immediately upon notification of concern on 07/07/16, Director of Nursing (DON) with the help of a Certified Nursing Assistant (C.N.A.), applied a chair pad alarm to resident # 6. On 07/08/16, a LPN Unit Manager (LPN) assessed history of falls, and the resident's fall care plan for fall prevention approaches. LPN then notified the Nurse Practitioner (NP) of findings and a verbal order to discontinue the chair pad alarm was written and approved.	

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F 323	Continued From page 45 resident's cognition as being severely impaired. Section G documented the resident required extensive assistance of one staff with locomotion and was coded as totally dependent on two or more staff with transfers. Section J documented Resident #6 had not sustained a fall since the prior assessment. Review of Resident #6's clinical record revealed a fall risk evaluation dated 6/7/16 that documented the resident was at risk for falls. A nurse's note dated 6/7/16 documented, "CNA (certified nursing assistant) came to this nurse stating resident was on the floor beside bed. This nurse entered the room and resident was sitting o0n (sic) bottom with knees bent leaning with right side against bed and right arm on mattress..." A physician order summary signed by the physician on 7/1/16 documented, "8/25/2015-pressure alarm to bed and chair as indicated TID (three times a day)...6/22/2016 Check to make sure safety device is working properly every shift. TID..." Resident #6's comprehensive care plan with an onset date of 1/15/15 documented, "At risk for fall related injury- As evidence by: Previous fall with injury; Fall Risk Scores Relating To: Generalized weakness; Cognitive deficits- dementia; Impaired mobility; Poor safety awareness...Approaches: Pressure alarm to bed/chair as indicated..." Observation of Resident #6 in a wheelchair near the nurse's station was conducted on 7/7/16 at 2:12 p.m. and 4:00 p.m. No pressure alarm was observed. On 7/7/16 at 4:05 p.m., an interview was	F 323	F323 Continued from Page 45 **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** Residents with orders for fall prevention safety alarms have the potential to be affected by this practice. On 07/25/16, a 100 % audit of medical records for fall prevention safety alarms was completed by Unit Managers (UM) to identify residents with alarms. A list was compiled and verification that ordered alarms were in place and working properly was completed. No other concerns were identified. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the practice will not reoccur.** Beginning on 07/25/16, education will be provided by IED, SDC and/or DON to licensed nurses and certified nursing assistants (CNA) regarding following physician orders for alarms and their responsibility to ensure fall prevention safety alarms are in place and working properly. Education will be completed by 08/05/16 and same education will be included in orientation for new hires.	

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F 323	Continued From page 46 conducted with CNA #6 (the CNA caring for Resident #6). CNA #6 was asked how she was made aware of safety interventions required for each resident. CNA #6 stated, "They have orders and our nurses let us know." CNA #6 stated Resident #6 was supposed to have a mat beside the bed and an alarm on the bed and chair. At this time, CNA #6 was asked to observe Resident #6 in the wheelchair. CNA #6 confirmed no alarm was present on the resident's wheelchair. On 7/7/16 at 4:12 p.m., an interview was conducted with LPN (licensed practical nurse) #5 (the nurse caring for Resident #6). LPN #5 was asked how she was made aware of safety interventions required for each resident. LPN #5 stated safety interventions were documented on the treatment books. LPN #5 stated Resident #6 was supposed to have a pressure alarm on the chair and bed. LPN #5 was made aware the resident did not have an alarm on the wheelchair. On 7/7/16 at 5:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility policy titled, "Falls Management" documented, "Policy: Each resident will be assessed throughout the course of treatment for different parameters such as: cognition, safety awareness, fall history, mobility, sensory status, medications, or predisposing health conditions that may contribute to fall risk. An interdisciplinary plan of care will be developed, implemented, reviewed and updated as necessary to reflect each resident's current safety needs and fall reduction interventions..."	F 323	F323 Continued from Page 46 Starting on 07/25/16, orders and 24 hour reports will be reviewed daily Monday through Friday during the Clinical IDT meeting to identify order changes related to fall prevention safety alarms. A list of fall prevention safety alarms will be maintained by the Unit Managers (UM) and updated as ordered by the Physician. Beginning on 07/25/16, observation audits will be completed by unit managers (UM) and/or Director of Nursing (DON) 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks to verify compliance with Physician's orders for fall prevention safety alarms. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audits for fall prevention safety alarms will be reported for review	

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F 323	Continued From page 47 No further information was presented prior to exit. (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating..." This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html	F 323	F323 Continued from Page 47 and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON or UM for 3 months or until 100% compliance is achieved.	08/05/16
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that the facility staff failed to ensure podiatry services were provide for two of 28 residents in the survey sample, Residents #4 and #3. 1. The facility staff failed to ensure a podiatry consult ordered for Resident #4 on 4/29/16 was provided.	F 328	**F328** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Residents # 4 and # 3 were identified as being affected by this practice. On 07/07/16, the Nurse Practitioner was consulted by Nurse Unit Manager and podiatry consult orders for resident # 4 and # 3 were discontinued. Neither resident was deemed by the Nurse Practitioner to have an immediate Podiatry concern. Both residents were placed on Podiatry list, orders written and appointments made for in-house Podiatry visit scheduled on 08/01/16.	

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F 328	Continued From page 48 2. The facility staff failed to ensure a podiatry consult for Resident #3 ordered on 3/29/16 was provided. The findings include: 1. Resident #4 was admitted to the facility on 2/9/16 with diagnoses including, but not limited to: chronic kidney disease, diabetes, congestive heart failure and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 5/18/16), she was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of staff for bed mobility, dressing, personal hygiene and bathing. On 7/8/16 at 11:10 a.m., observation was made of Resident #4's toenails. LPN (licensed practical nurse) #3, a unit manager, accompanied the surveyor and performed the assessment. Resident #4's right foot was assessed first, and revealed the second and third toenails were long. Resident #4's left foot revealed the third toenail was long. LPN #3 touched the first toenail on the right side and described it as "a little overgrown." A review of the physician's orders for Resident #4 revealed, in part, the following order, written on 4/29/16: "Podiatry consult with [name of podiatrist] for painful, thick, mycotic nails secondary to diabetes and arterial insufficiency." A review of the admission nursing assessment dated 4/29/16 revealed no documentation regarding the resident's toenails.	F 328	F328 Continued from Page 48 **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All residents residing in the facility have the potential to be affected by this practice. On 07/29/2016, Nurse Unit Managers (UM) completed an observation of all in-house resident's toe nails to identify residents with Podiatry needs. Any resident identified with a Podiatry need has a scheduled appointment to see in-house podiatrist. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** Education, starting on 07/25/16 will be provided by IED, SDC and/or DON to licensed nurses, the Health Information Manager (HIM) and assistant HIM manager regarding proper procedure for referring a resident to Podiatry upon admission, readmission and as needed.	

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F 328	Continued From page 49 A review of the TARs (treatment administration records) and nurses notes revealed no evidence that Resident #4 had been referred to a podiatrist as ordered by the physician. A review of the comprehensive care plan for Resident #4 dated 4/29/16 failed to reveal information related to podiatry services. On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. Policies and procedures regarding podiatry services were requested. On 7/8/16 at 8:30 a.m., ASM #2 stated that the facility did not have a policy related to podiatry services. On 7/8/16 at 10:10 a.m., LPN #4 was interviewed. She stated unit managers are responsible for generating the lists of residents to be seen by the podiatrist. LPN #4 stated: "Floor nurses don't make those lists." On 7/8/16 at 10:15 a.m., LPN #2, a unit manager was interviewed. LPN #2 stated: "If it's ordered like that, and not prn (as-needed), then an appointment should be scheduled. It looks like this was done as an admission order. It should have been done through medical records/transportation. I don't generate a list of consults needed when someone is admitted. Medical records goes through the admitting orders and checks them for appointments that are needed. She (medical records employee) makes the appointments off of the orders."	F 328	F328 Continued from Page 49 Education will be completed by 08/05/16 and the same education will be included in orientation for new hires. An on-going referral list will be compiled by the HIM Director or HIM assistant based on communication in the clinical IDT meeting held Monday through Friday. Podiatry appointments will be scheduled upon identification of need and MD order obtained at that time. The HIM director will maintain the on-going audit of podiatry consults needed, identifying both in-house and external podiatry consults. This audit will track when referrals are made, orders are written and when Podiatry services were performed to ensure compliance. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of HIM audits for podiatry services referred, ordered and completed will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON or HIM Director for 3 months or until 100% compliance is achieved.	08/05/16

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F 328	Continued From page 50 On 7/8/16 at 10:30 a.m., OSM (other staff member) #2, the medical records clerk, was interviewed. OSM #2 stated: "I do not have a role with the podiatrist with admission orders. If a nurse indicates that a podiatrist is needed, then I add that resident to the list. I've never been told to include podiatry consults in any kind of screening process on admission." No further information was provided prior to exit. 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." 2. Resident #3 was admitted to the facility on 2/19/15 and readmitted on 3/29/16 with diagnoses including, but not limited to: history of a stroke with one-sided paralysis, depression, enlarged prostate with obstruction, and chronic kidney disease. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date, he was coded as being moderately cognitively impaired for making decisions. He was coded as requiring the extensive assistance of two staff members for bed mobility, transfers and personal hygiene. He was coded as being dependent on staff members for toileting and bathing. On 7/8/16 at 11:15 a.m., observation was made of Resident #3's toenails. LPN (licensed practical nurse) #3, a unit manager, accompanied the surveyor and performed the assessment. Resident #3's right foot was assessed first, and	F 328		

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revealed, the third, fourth and fifth toes contained long nails. LPN #3 stated: "I'd say they are getting a little long. Especially the big one."

A review of the physician's orders for Resident #3 revealed, in part, the following order, written on 3/29/16: "Podiatry consult for long thick painful toe nails."

A review of the admission nursing assessment dated 3/29/16 revealed no documentation regarding the resident's toenails.

A review of the TARs (treatment administration records) and nurses notes revealed no evidence that Resident #3 had been referred to a podiatrist as ordered by the physician.

A review of the comprehensive care plan for Resident #3 dated 3/29/16 failed to reveal information related to podiatry services.

On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. Policies and procedures regarding podiatry services were requested.

On 7/8/16 at 8:30 a.m., ASM #2 stated that the facility did not have a policy related to podiatry services.

On 7/8/16 at 10:10 a.m., LPN #4 was interviewed. She stated unit managers are responsible for generating the lists of residents to be seen by the podiatrist. LPN #4 stated: "Floor nurses don't make those lists."

On 7/8/16 at 10:15 a.m., LPN #2, a unit manager

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F 328	Continued From page 52 was interviewed. LPN #2 stated: "If it's ordered like that, and not prn (as-needed), then an appointment should be scheduled. It looks like this was done as an admission order. It should have been done through medical records/transportation. I don't generate a list of consults needed when someone is admitted. Medical records goes through the admitting orders and checks them for appointments that are needed. She (medical records employee) makes the appointments off of the orders." On 7/8/16 at 10:30 a.m., OSM (other staff member) #2, the medical records clerk, was interviewed. OSM #2 stated: "I do not have a role with the podiatrist with admission orders. If a nurse indicates that a podiatrist is needed, then I add that resident to the list. I've never been told to include podiatry consults in any kind of screening process on admission." No further information was provided prior to exit.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329	**F329** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident #9 was identified in this practice. A behavioral monitoring flow sheet was put into place on 07/09/16 by Director of Nursing (DON) for documenting effectiveness of PRN medication. Resident # 9's Comprehensive Care Plan was reviewed by DON, Unit Managers (UM), Social	

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F 329	Continued From page 53 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. 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 monitor the use of a hypnotic (medication used to promote sleep) for one of 28 residents in the survey sample, Resident #9. The facility staff failed to ensure the effectiveness of the medication, Restoril (used to treat insomnia (1)) was monitored for Resident #9. The findings include: Resident #9 was admitted to the facility on 3/3/12 with diagnoses that included but were not limited to: pneumonia, high blood pressure, low back pain, dementia, pain, hypothyroid disease, and dysphagia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/14/16, coded the resident as being severely impaired to make daily cognitive decisions. Resident #9 was coded as	F 329	F329 Continued from Page 53 Services Director (SSD) and MDS coordinators on 07/19/16 and updated to include the problem of insomnia and approaches. On 07/27/16, a medication review was completed by Medical Doctor (MD) to ensure current medications were still appropriate for continued use. No new orders were obtained relating to the hypnotic medication. **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** Residents who have orders for PRN hypnotic medications have the potential to be affected. An audit of in-house resident's MAR's was completed by the Unit Managers (UM) on 07/21/16 to identify other resident's with PRN orders for hypnotic medications. The UM also verified behavior monitoring sheets for residents were in place as indicated and effectiveness was being monitored and documented	

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F 329	Continued From page 54 requiring extensive assistance of one or more staff members for most of her activities of daily living. Resident #9 was coded as requiring limited assistance of one staff member for eating. The physician orders, dated, 5/1/16, documented, "Restoril 7.5 mg (milligram) capsule PO (by mouth) qhs (every bedtime) prn (as needed); 1 cap (capsule) by mouth nightly as needed." The review of the May 2016 MAR (medication administration record) documented the administration of Restoril on the following dates: 5/2/16, 5/4/16, 5/20/16, 5/24/16, and 5/28/16. Three of the above dates were documented on the reverse of the MAR. There was no effectiveness documented for the prn Restoril. Review of the nurse's notes for May 2016, did not reveal any documentation of the administration or effectiveness of the medication. The "Behavior/Intervention Monthly Flow Record" documented, "This monitoring form is to be used for the following drug classes when appropriate (check if applicable). Antianxiety Agent, Antipsychotic, Sedative/Hypnotic." The "Behavior/Intervention Monthly Flow Record" for May 2016 documented, "Anxiety and Yelling" as the behaviors. There was no documentation for insomnia/sleep." The review of the June 2016 MAR documented the administration of Restoril on the following dates: 6/13/16, 6/16/16, and 6/17/16, four of the above were documented on the reverse of the MAR but there was no effectiveness documented. Review of the nurse's notes for June 2016, did not reveal any documentation related to the effectiveness of the Restoril administration.	F 329	F329 Continued from Page 54 appropriately. Care plans for all residents identified on PRN hypnotics were reviewed and updated accordingly by DON, MDS Nurse, or UM on 07/25/16. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** Beginning on 07/25/16, education will be provided by SDC and/or DON to Licensed nurses and Social Services staff related to following physician's orders, including verifying documentation of effectiveness of medication and use of behavior monitoring sheets. Education will also include updating the resident Psychotropic Medication care plan regarding changes identified. Education will be completed by 8/05/16. Same education will be included in orientation for new hires. Starting 07/27/2016 , a UM or DON will perform 5 observations per week for 4 weeks, then 3 observations for 4 weeks,	

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F 329	Continued From page 55 The "Behavior/Intervention Monthly Flow Record" for June 2016 documented, "Anxiety and Yelling" as the behaviors. There was no documentation for insomnia/sleep." The review of the July 2016 MAR documented the administration of the Restoril on the following dates: 7/3/16 and 7/4/16. Both of them were on the reverse of the MAR but there was no effectiveness documented. Review of the July 2016, nurse's notes did not reveal any documentation of the effectiveness. The comprehensive care plan dated, 12/8/15 and revised on 3/16/16 documented, "Behavior problem: The resident will yell out during the day and night." The "Approaches" documented in part, "Administer and observe the effectiveness and side effects of medications as ordered (see physician's orders/MAR)." An interview was conducted with LPN (licensed practical nurse) #4 on 7/7/16 at 12:36 p.m. regarding residents requests for a PRN (as needed) medication for pain, sleep, anxiety or fever. LPN #4 stated, "You sign it out on the back of the MAR and the effectiveness." When asked if all PRN medications require effectiveness documented, LPN #4 stated, "Yes, there should be effectiveness for all of them. You'd want to know if the fever came down, or the pain went away or they slept." An interview was conducted with LPN #3; the unit manager, on 7/7/16 at 12:47 p.m. regarding the process followed when a resident complains of pain, fever, or can't sleep. LPN #3 stated, "You go check the MAR to see if they have a	F 329	F329 Continued from Page 55 then weekly observations for 4 weeks for residents on PRN hypnotic medication to ensure behavior monitoring sheets are complete, effectiveness was documented and care plans were appropriately reviewed and updated. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of PRN hypnotic MAR, behavior monitoring sheet observations including documentation of effectiveness and care plan updates will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON or UM for 3 months or until 100% compliance is achieved.	08/05/16

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F 329	Continued From page 56	F 329		

medication to treat what they are complaining of. If so you administer the medication, sign it off on the front of the MAR and then put it on the reverse of the MAR except pain, which goes on the pain flow sheet." When asked if the use of Restoril for insomnia should have the effectiveness of the medication documented, LPN #3 stated, "Yes, it should have effectiveness too."

An interview was conducted with administrative staff member (ASM) #2 on 7/7/16 at 1:04 p.m. When asked how a nurse is to document the use of a PRN medication, ASM #2 stated, "First they see if there is a PRN for what the resident is complaining about. If a medication order is available, they sign it on the MAR and write the information on the back of the MAR as to what it was and should write the effectiveness." When asked if that applies to the use of a hypnotic such as Restoril, the director of nursing, ASM #2 stated, "Yes it should be on the MAR or in a nurse's note."

The facility policy, "Sedative/Hypnotics" documented in part, "Sedative/Hypnotic drugs can be considered unnecessary if no attempt has been made to determine and correct the reason for the inappropriate sleep pattern. They can also be considered a chemical restraint...Usage of sedative/hypnotics and dose reduction possibilities should be routinely reviewed in the psychotropic medication meeting or resident at risk meeting. Monitoring for Efficacy: Efficacy is easily determined by a resumption of a normal (for that individual) pattern of sleep. Monitor hours of sleep with the use of sedative/hypnotic medications as needed."

According to Fundamentals of Nursing, 5th

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F 329	Continued From page 57 edition, Craven and Hirnle, Lippincott, Williams & Wilkins, page 565, "Nurses also are responsible for documenting the therapeutic effects and side effects of any medication administered." The executive director and ASM #2 were made aware of the above findings on 7/7/16 at 5:28 p.m. No further information was provided prior to exit. (1) Temazepam (Restoril) is used on a short-term basis to treat insomnia (difficulty falling asleep or staying asleep). Temazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow sleep. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a684003.html	F 329		
F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. 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 ensure the physician wrote, dated and signed a progress note at each required visit for 9 of 28 residents in the survey	F 386	**F386** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Residents #11, #3, #4, #8, #2, #12, #13, #10 and #9 were cited as being affected by this practice. 1. Resident # 11 – Notes from visits on: 07/24/15, 09/22/15, 11/27/15, 01/28/16, 04/06/16 were dictated on 07/07/16 and placed in medical record on 07/07/16.	

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F 386	Continued From page 58 sample, Residents #11, #3, #4, #8, #2, #12, #13, #10 and #9. 1. Resident #11's physician failed to write, date, sign and place progress notes on the clinical record for visits made on 7/24/15, 9/22/15, 11/27/15, 1/28/16 and 4/6/16. 2. Resident #3's physician failed to write, date, sign and place progress notes on the record for visits made on 3/30/16 and 6/16/16. 3. Resident #4's physician failed to write, date, sign and place progress notes on the record for visits made on 3/9/16, 4/5/16, 5/27/16 and 7/1/16. 4. Resident #8's physician failed to write, date, sign and place progress notes on the record for visits made on 11/13/15, 1/8/16, 2/23/16 and 6/18/16. 5. Resident # 2 had no physician progress notes in the clinical record (written, dated, or signed). 6. Resident # 12 had no physician progress notes in the clinical record (written, dated, or signed). 7. Resident # 13 had no physician progress notes in the clinical record (written, dated, or signed). 8. Resident # 10's clinical record had no physician re-certification for services note from 7/9/15 to 7/7/16, and the facility staff failed to ensure the physician dated a note for 3/25 to include the year (no year was documented).	F 386	F386 Continued from Page 58 2. Resident # 3 – Handwritten notes for physician visits on 03/30/16 and 06/16/16 were signed and dated by the Medical Director and were placed on the medical record on 07/26/16. 3. Resident # 4 – Handwritten notes for physician visits on 03/19/16, 04/15/16, 05/27/16 and 07/01/16 were signed and dated by the Medical Director and placed on medical record on 07/26/16. 4. Resident # 8 – Handwritten notes for physician visits on 11/13/15, 01/08/16, 02/23/16, 06/18/16 were signed and dated by the Medical Director and placed on the medical record on 07/26/16. 5. Resident # 2 - Handwritten and dictated notes for physician visits on 02/01/16, 02/09/16, 02/19/16, 04/29/16, 05/27/16 and 07/06/16 were signed and dated by the Medical Director and placed on the medical record on 07/26/16.	

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

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F 386	Continued From page 59 9. There were no physician progress notes in the clinical record for Resident #9 since 12/7/15. The findings include: 1. Resident #11's physician failed to write, date, sign and place progress notes on the clinical record for visits made on 7/24/15, 9/22/15, 11/27/15, 1/28/16 and 4/6/16. Resident #11 was admitted to the facility on 9/19/14. Resident #11's diagnoses included but were not limited to: chronic kidney disease, high blood pressure and pain. Resident #11's most recent MDS (minimum data set), a significant change in status assessment, with an ARD (assessment reference date) of 6/17/16, coded the resident's cognition as moderately impaired. Review of Resident #11's clinical record failed to reveal physician recertification progress notes for each required visit during the time period of 7/24/15 through 4/6/16. On 7/7/16 at 11:15 a.m., ASM (administrative staff member) #2 (the director of nursing) confirmed Resident #11's physician's recertification progress notes were not in the clinical record and had to be printed out. Review of Resident #11's printed physician's recertification notes revealed the resident was seen by the physician on 7/24/15, 9/22/15, 11/27/15, 1/28/16 and 4/6/16; however, the printed notes were not electronically signed by the physician until 7/7/16. On 7/7/16 at 10:55 a.m., an interview was conducted with OSM (other staff member) #2 (the medical records employee). OSM #2 stated she	F 386	F386 Continued from Page 59 6. Resident # 12 - Handwritten and dictated notes for physician visits on 03/26/16 and 05/27/16 were signed and dated by the Medical Director and placed on the medical record on 07/26/16. 7. Resident # 13 - Handwritten and dictated notes for physician visits on 12/05/15, 02/23/16, 05/24/16, and 07/27/16 were signed and dated by the Medical Director and placed on the medical record on 07/27/16. 8. Resident # 10 - Handwritten and dictated notes for physician visits on 03/26/16, 05/26/16 and 07/27/16 were signed and dated by the Medical Director and placed on the medical record on 07/27/16. 9. Resident # 9 - Handwritten and dictated notes for physician visits on 11/09/15, 12/07/15, 02/02/16, 04/07/16, 05/05/16, and 05/15/16 were signed and dated by the Medical Director and placed on the medical record on 07/26/16.	

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F 386	Continued From page 60 gives ASM (administrative staff member) #3 (Resident #11's physician) a list of residents who need to be seen for recertification every week. OSM #2 stated ASM #3 keeps handwritten notes from each visit but doesn't always get the notes typed and on the chart. OSM #2 stated ASM #3 has asked for help regarding this matter and was supposed to receive help the following week. On 7/7/16 at 3:17 p.m., an interview was conducted with ASM #3. ASM #3 stated medical records had been a huge issue. ASM #3 stated he had been asking his bosses for a solid week to "catch up and help to stay caught up." ASM #3 stated his bosses didn't have anyone authorized to assist him until the following week. ASM #3 stated other physicians' notes didn't contain enough information but he (ASM #3) used the review of systems, hand scribbled notes then dictated the notes. ASM #3 stated his handwritten notes were for his personal use to dictate his typed notes. When asked if his handwritten notes were signed, dated and placed on the chart, ASM #3 stated, "No because I don't consider them part of the permanent record." ASM #3 stated he was always behind on dictations, especially for routine visits. ASM #3 was made aware Resident #11's printed notes were electronically signed by him on this same day (7/7/16). ASM #3 confirmed he had dictated the notes this same day. ASM #3 stated he had been pulling together his handwritten notes and dictating typed notes this day because the dictated notes were supposed to be on the clinical record. ASM #3 stated he has an assistant who is supposed to help enter information into the computer but the computer system would not allow his assistant to do so because of HIPAA (health insurance portability	F 386	F386 Continued from Page 60 **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All in-house residents have the potential to be affected by this practice. A medical record audit was completed by the HIM director on 07/13/2016 to indicate last physician and/or nurse practitioner visit filed in the chart. Interim Executive Director (IED) and the Physician/Medical Director (MD) were notified of the results of the audit on 07/13/2016 by the HIM director. The Interim Executive Director (IED) met with the Medical Director (MD) on 07/18/2016 and a plan was put in place to correct all concerns identified by the HIM audit. All concerns will be addressed by 07/29/2016. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** The Medical Director, Nurse	

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F 386	Continued From page 61 and accountability act) (1) regulations. On 7/7/16 at 5:25 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility policy titled, "Physician Services Guidelines" documented, "Policy: Documentation in the medical record must reflect supervision of medical care of each resident in the facility. All opinions that require physician judgement are signed and dated only by the physician or his designated representative (i.e., physician's assistant, clinical nurse specialist, or nurse practitioner) per state guidelines...At the time of each visit, the physician must review the resident's total program of care, medications, treatments, and the care plan. A progress note must be written, signed, and dated at the time of each visit and include the following. Significant change in condition... Change in diagnosis Change in medications... Progress and problems in meeting care plan goals Measures taken to reach highest practical mental/physical functional level... Status of specialized treatments and medical indications... Documentation regarding advanced directives... " No further information was presented prior to exit. (1) Health Insurance Portability and Accountability Act (HIPAA) - "Most of us believe that our medical and other health information is private and should be protected, and we want to know who has this information. The Privacy Rule, a Federal law, gives you rights over your health information and	F 386	F386 Continued from Page 61 Practitioner and other Attending Physician were educated by the Interim Executive Director on 07/12/2016 regarding policy and procedure for documenting physician visits. To properly document a physician visit in the chart there must be a written progress note placed on the medical record at time of visit. This can be written as progress note or a Physician's Visit Form or a brief notation regarding the visit including date and signature with notation that dictation will follow. A Physician's Visit /Recertification form was put in place for all visits when a dictated note will not be completed within 72 hours. The physician completing the visit will complete the form, including signature and date and the handwritten documentation will be given to HIM or HIM assistant to update the documentation audit and then placed on the medical record until dictation is available. Health Information Manager (HIM) or HIM assistant will audit required	

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F 386	Continued From page 62 sets rules and limits on who can look at and receive your health information. The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written, or oral. The Security Rule is a Federal law that requires security for health information in electronic form." This information was obtained from the website: http://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html 2. Resident #3's physician failed to write, date, sign and place progress notes on the record for visits made on 3/30/16 and 6/16/16. Resident #3 was admitted to the facility on 2/19/15 and readmitted on 3/29/16 with diagnoses including, but not limited to: history of a stroke with one-sided paralysis, depression, enlarged prostate with obstruction, and chronic kidney disease. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date of 5/4/16, he was coded as being moderately cognitively impaired for making decisions. A review of the physician's progress notes for Resident #3 revealed no notes since the 3/29/16 readmission. On 7/7/16 at 3:15 p.m., ASM (administrative staff member) #3, Resident #3's attending physician and the facility medical director, was interviewed. He stated he was aware that getting his notes typed and placed in the medical record had been "a huge issue here." He stated that he makes the required visits, but is weeks, sometimes months, behind in getting the progress note typed and placed in the medical record. He stated: "Is it acceptable? No. But it's the best I can do." He	F 386	F386 Continued from Page 62 physician visits and keep a running log of physician documentation needed. A list of all visits documented directly in the medical record or completed hand written or dictated notes be given to HIM department for verification of completeness and filed on the medical record. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audit regarding physician notes being placed on the medical record will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the HIM director, HIM assistant or IED for at least 3 months or until 100% compliance is achieved.	08/05/16

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F 386	Continued From page 63 stated he keeps hand-written notes from each visit, then later types the notes and gives them to the facility staff for placement in the clinical record. On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. On 7/8/16 at 8:30 a.m., the surveyor was provided with evidence of ASM #3's hand-written notes for visits to Resident #3 on 3/30/16 and 6/16/16. No further information was provided prior to exit. 3. Resident #4's physician failed to write, date, sign and place progress notes on the record for visits made on 3/9/16, 4/5/16, 5/27/16 and 7/1/16. Resident #4 was admitted to the facility on 2/9/16 with diagnoses including, but not limited to: chronic kidney disease, diabetes, congestive heart failure and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 5/18/16, she was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). A review of physician progress notes revealed no recertification notes since the resident was admitted on 2/9/16. On 7/7/16 at 3:15 p.m., ASM (administrative staff	F 386		

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	495139	A. BUILDING _____ B. WING _____	07/08/2016

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F 386	Continued From page 64 member) #3, Resident #4's attending physician and the facility medical director, was interviewed. He stated he was aware that getting his notes typed and placed in the medical record had been "a huge issue here." He stated that he makes the required visits, but is weeks, sometimes months, behind in getting the progress note typed and placed in the medical record. He stated: "Is it acceptable? No. But it's the best I can do." He stated he keeps hand-written notes from each visit, then later types the notes and gives them to the facility staff for placement in the clinical record. On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. On 7/8/16 at 8:30 a.m., the surveyor was provided with evidence of ASM #3's hand-written notes for visits to Resident #4 on 3/9/16, 4/5/16, 5/27/16 and 7/1/16. No further information was provided prior to exit. 4. Resident #8's physician failed to write, date, sign and place progress notes on the record for visits made on 11/13/15, 1/8/16, 2/23/16 and 6/18/16. Resident #8 was admitted to the facility on 6/27/13 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, chronic back pain and anxiety disorder. On the most recent MDS (minimum data set), an annual assessment dated 6/10/16, Resident #8 was	F 386		

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F 386	Continued From page 65 coded as being cognitively intact for making daily decisions. A review of the clinical record failed to reveal evidence of physician recertification visits since 7/13/15. On 7/7/16 at 3:15 p.m., ASM (administrative staff member) #3, Resident #8's attending physician and the facility medical director, was interviewed. He stated he was aware that getting his notes typed and placed in the medical record had been "a huge issue here." He stated that he makes the required visits, but is weeks, sometimes months, behind in getting the progress note typed and placed in the medical record. He stated: "Is it acceptable? No. But it's the best I can do." He stated he keeps hand-written notes from each visit, then later types the notes and gives them to the facility staff for placement in the clinical record. On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. On 7/8/16 at 8:30 a.m., the surveyor was provided with evidence of ASM #3's hand-written notes for visits to Resident #8 on 11/13/15, 1/8/16, 2/23/16 and 6/18/16. No further information was provided prior to exit. 5. Resident # 2 had no physician progress notes in the clinical record (written, dated, or signed). Resident # 2 was admitted to the facility on 1/4/16 and most recently readmitted on 3/4/16 with diagnoses that included but were not limited to:	F 386		

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F 386	Continued From page 66 hypertension, hyperlipidemia, dementia, hypothyroidism, atrial fibrillation, and depression. Resident # 2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/27/16, coded Resident # 2 as understood by others and able to understand others. Resident # 2 was coded as scoring 11 of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was moderately cognitively impaired. Review of the clinical record revealed no physician progress notes by the attending physician. During an interview on 7/7/16 at 11:50 a.m. with OSM (other staff member) # 2 (medical records), OSM # 2 revealed that every week she (OSM # 2) makes a list of all residents that need to be seen by the physician. OSM # 2 stated that she gives the list to the physician each week; OSM # 2 stated that the physician does handwritten notes, then takes the notes and types them up. OSM # 2 further stated that the typed notes don't always get on the chart. During an interview on 7/7/16 at 3:17 p.m. with ASM (administrative staff member) # 3, the physician, revealed that records are a problem stating, "I've been asking for help for some time to do all the paperwork. I'm getting help next week. I'm always behind in dictation. My hand written notes are not acceptable - what use is a note that you can't read. I recognize that it is a problem. I have handwritten notes for each resident but do not consider my notes a part of	F 386		

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F 386	Continued From page 67 the record so I do not date and sign them." ASM # 3 was asked if we could see his notes. ASM # 3 responded that we could. During the end of day interview on 7/7/16 at 5:30 p.m. with ASM (administrative staff member) # 1, executive director, and ASM # 2, director of nurses, were made aware of the missing physician progress issue. At this time a request was made for the facility policy. On 7/8/16 at 8:25 a.m. a list of the dates for each visit for each resident was provided by ASM # 1, the executive director. This list documented that ASM # 3 visited Resident # 2 on 2/9/16, 2/29/16, 3/5/16, 4/1/16, 4/29/16, and 5/27/16. The notes corresponding to these dates were also provided and as ASM # 3 stated they were not signed or dated. During an interview on 7/8/16 at 8:32 a.m. with ASM # 2, ASM # 2 stated, "I presented everything I have." No further information was provided prior to exit. 6. Resident # 12 had no physician progress notes in the clinical record (written, dated, or signed). Resident # 12 was admitted to the facility on 6/20/14 and most recently readmitted on 7/17/15 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease, congestive heart failure, hypertension, hyperlipidemia, hypothyroidism, atrial fibrillation, congestive heart failure, and bi-polar disorder*.	F 386		

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F 386	Continued From page 68 Resident # 12's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/15/16, coded Resident # 12 as understood by others and able to understand others. Resident # 12 was coded as scoring 15 of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was cognitively intact. *Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels. www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml Review of the clinical record revealed no physician progress notes by the attending physician. During an interview on 7/7/16 at 11:50 a.m. with OSM (other staff member) # 2 (medical records), OSM # 2 revealed that every week she (OSM # 2) makes a list of all residents that need to be seen by the physician. OSM # 2 stated that she gives the list to the physician each week; OSM # 2 stated that the physician does handwritten notes, then takes the notes and types them up. OSM # 2 further stated that the typed notes don't always get on the chart. During an interview on 7/7/16 at 3:17 p.m. with ASM (administrative staff member) # 3, the physician, revealed that records are a problem stating, "I've been asking for help for some time to do all the paperwork. I'm getting help next	F 386		

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F 386	Continued From page 69 week. I'm always behind in dictation. My hand written notes are not acceptable - what use is a note that you can't read. I recognize that it is a problem. I have handwritten notes for each resident but do not consider my notes a part of the record so I do not date and sign them." ASM # 3 was asked if we could see his notes. ASM # 3 responded that we could. During the end of day interview on 7/7/16 at 5:30 p.m. with ASM (administrative staff member) # 1, executive director, and ASM # 2, director of nurses, were made aware of the missing physician progress issue. At this time a request was made for the facility policy. On 7/8/16 at 8:25 a.m. a list of the dates for each visit for each resident was provided by ASM # 1, the executive director. A list of the dates for each visit for each resident was provided. This list documented that ASM # 3 visited Resident # 12 on 12/4/15, 1/29/16, 3/25/16, and 5/20/16. Only one note corresponding to these dates was provided (3/25/16) and as ASM # 3 stated it was not signed or dated. During an interview on 7/8/16 at 8:32 a.m. with ASM # 2, ASM # 2 stated, "I presented everything I have." No further information was provided prior to exit. 7. Resident # 13 had no physician progress notes in the clinical record (written, dated, or signed). Resident # 13 was admitted to the facility on 6/20/06 and most recently readmitted on 1/30/15	F 386		

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F 386	Continued From page 70 with diagnoses that included but were not limited to: congestive heart failure, hyperlipidemia, diabetes, multiple sclerosis*, and gastroesophageal reflux disorder. Resident # 13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/1/16, coded Resident # 13 as understood by others and able to understand others. Resident # 13 was coded as scoring 11 of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was moderately cognitively impaired. *Multiple sclerosis (MS) is a disease of the central nervous system. In MS the body's immune system attacks myelin, which coats nerve cells. nccih.nih.gov/health/multiple-sclerosis Review of the clinical record revealed no physician progress notes by the attending physician. During an interview on 7/7/16 at 11:50 a.m. with OSM (other staff member) # 2 (medical records), OSM # 2 revealed that every week she (OSM # 2) makes a list of all residents that need to be seen by the physician. OSM # 2 stated that she gives the list to the physician each week; OSM # 2 stated that the physician does handwritten notes, then takes the notes and types them up. OSM # 2 further stated that the typed notes don't always get on the chart. During an interview on 7/7/16 at 3:17 p.m. with ASM (administrative staff member) # 3, the physician, revealed that records are a problem stating, "I've been asking for help for some time	F 386		

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F 386	Continued From page 71 to do all the paperwork. I'm getting help next week. I'm always behind in dictation. My hand written notes are not acceptable - what use is a note that you can't read. I recognize that it is a problem. I have handwritten notes for each resident but do not consider my notes a part of the record so I do not date and sign them." ASM # 3 was asked if we could see his notes. ASM # 3 responded that we could. During the end of day interview on 7/7/16 at 5:30 p.m. with ASM (administrative staff member) # 1, executive director, and ASM # 2, director of nurses, were made aware of the missing physician progress issue. At this time a request was made for the facility policy. On 7/8/16 at 8:25 a.m. a list of the dates for each visit for each resident was provided by ASM # 1, the executive director. A list of the dates for each visit for each resident was provided. This list documented that ASM # 3 visited Resident # 13 on 12/4/15, 3/25/16, and 5/20/16. No notes corresponding to these dates were provided. During an interview on 7/8/16 at 8:32 a.m. with ASM # 2, ASM # 2 stated, "I presented everything I have." No further information was provided prior to exit. 8. Resident # 10's clinical record had no physician re-certification for services note from 7/9/15 to 7/7/16, and the facility staff failed to ensure the physician dated a note for 3/25 to include the year (no year was documented). Resident #10 was admitted to the facility on	F 386		

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F 386	Continued From page 72 1/8/16 with diagnoses that included but were not limited to: arthritis, dementia, high blood pressure, kidney disease and diabetes. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 4/13/16 coded the resident as having a six out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. Review of the clinical record did not evidence documentation of a physician re-certification for services note from 7/9/15 to 7/7/16. A request was made to ASM (administrative staff member) #2, the director of nursing, on 7/7/16 for all of the physician progress notes for Resident #10. An interview was conducted on 7/7/16 at 11:00 a.m. with OSM (other staff member) #2, the medical records manager. When asked if the physician's progress notes were to be in the chart, OSM #2 stated that they should be. When asked the process she followed to track the physician's visits, OSM #2 stated, "I make a list every week and give it to the doctor." OSM #2 stated that the physician had handwritten notes but had not put them into the computer so the notes were not available in the resident's clinical record. An interview was conducted on 7/7/16 at 3:18 p.m. with ASM #3, the physician. When asked about his notes, ASM #3 stated, "When asking for records it's a huge issue here. I have been asking my bosses to give me a solid week off and then some help to keep up with it. Some doctors	F 386		

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F 386	Continued From page 73 write notes you can't read. I scribble notes as I go along and then dictate my notes, I'm always behind in my dictation. I keep a list of when I see recerts." ASM #3 showed the form that he completes when he examines the residents. When asked if he signed and dated his handwritten notes, ASM #3 stated, "No, because I don't think it's part of the permanent record." When asked if it was acceptable that there were no physician notes on the chart, ASM #3 stated, "No." On 7/7/16 at 5:15 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. On 7/8/16 at 8:30 a.m. ASM #2 brought the physician's handwritten note dated 3/25 (no year documented). When asked if there were any other notes, ASM #2 stated, "If there is something you didn't get, we don't have it." Review of the facility's policy titled, "Physician Services Guidelines" documented, "Policy. Documentation in the medical record must reflect supervision of the medical care of each resident in the facility. All opinions that require physician judgement are signed and dated....Procedure. A progress note must be written, signed and dated at the time of each visit...A dictated progress note is acceptable, provided the physician writes, signs and dates a progress note that indicates that a note was dictated and will be transcribed." No further information was provided prior to exit. 9. There were no physician progress notes in the clinical record for Resident #9 since12/7/15.	F 386		

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F 386	Continued From page 74 Resident #9 was admitted to the facility on 3/3/12 with diagnoses that included but were not limited to: pneumonia, high blood pressure, low back pain, dementia, pain, hypothyroid disease, and dysphagia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/14/16, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. Resident #9 was coded as requiring limited assistance of one staff member for eating. Review of the clinical record revealed the last documented physician visit to be 12/7/15. There were multiple notes by the nurse practitioner but none by the physician for Resident #9. An interview was conducted with other staff member (OSM) #2, the medical records employee, on 7/7/16 at 10:59 a.m. When asked who tracks physician visits, OSM #2 stated, "I do." She further expanded stating, "He (physician) has handwritten sheets. He has them in a pile in his office until he puts them in the computer. He has asked for help and it's coming next week. I have asked and asked for him to do things but I can't make him do something. I've even contacted my corporate person. He takes notes and then doesn't put it in the computer. He's employed by a physician service within our corporation." A request was made to speak with the physician. An interview was conducted with ASM #3, the	F 386		

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F 386	Continued From page 75 physician for Resident #9, on 7/7/16 at 3:20 p.m. ASM #3 stated, "It's a huge issue here. I work for an (name of corporation) affiliate. I wanted a solid week to catch up. They have finally gotten me coverage next week so I can dictate my notes. When someone comes in, I write a handwritten H & P (history and physical) but it's unreadable. I hand scribble notes and then dictate afterwards. I am always behind in dictations. Especially for ones who don't get seen with too many care concerns. I have an assistant who was to help me put them in the computer but they won't allow her to put them in the computer." When asked how he knows who to see, ASM #3 stated, "I have a list of people I see." ASM #3 further stated, "Is this acceptable, no but my notes would be shorter. I want my notes to be readable and have all of the information on them. The routine stuff, I keep a list of recerts (recertification's). The recerts usually are done on Tuesday, Wednesday and Thursday. I run around and scribble a note." When asked if he was aware of the regulations regarding the physician visits and progress notes, ASM #3 stated, "Yes, I am." ASM #3 further stated, "When I do a recert, I look at the medications, lab results, dose reductions. The nurse practitioner cannot do the recerts. When I do the recerts, that's the time I review the nurse practitioner's work." When asked what would happen if something happened to him, ASM #3 stated, "It would be a mess but I feel there is enough information that could be used to follow the care. But that's my problem; I want the notes to be more readable and accurate. It's not good. I'm putting together my handwritten notes into the computer for the ones you have requested." On 7/7/16 at 4:46 p.m. ASM #3 brought a list of	F 386		

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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 386	Continued From page 76 resident names and handwritten notes of when they were seen. ASM #3 stated, "I do not have any list prior to December." The list documented Resident #7 was seen on 1/30/16, 4/7/16 and 5/5/16. ASM #3 was requested to provide the handwritten notes for these visits. The executive director and ASM #2, the director of nursing, were made aware of the above findings on 7/7/16 at 5:28 p.m. A request was made to provide evidence of the physician visits for Resident #9 since 12/7/15. On 7/8/16 at 8:27 a.m. three handwritten progress notes were received for 2/2/16, 4/7/16 and 5/5/16. No further information was provided prior to exit.	F 386		
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. 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 ensure timely physician visits for 6 of 28 residents in the survey sample, Residents #6, #8, #13, #1, #10 and #7	F 387	**F387** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Residents # 6, # 8, # 13, # 1, # 10, and # 7 were identified as being affected by this deficient practice.	

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F 387	Continued From page 77 1. The facility staff failed to provide documentation to evidence Resident #6 was seen by the physician for recertification from 12/30/15 until 6/30/16 (a total of 183 days). 2. The facility staff failed to provide physician visits to Resident #8 between 7/13/16 and 11/13/15 (120 days); and between 2/23/16 and 6/8/16 (104 days). 3. The physician (per the physician's list of visits) did not examine Resident # 13 from 12/4/15 until 3/25/16 (a period of 111 days). 4. Facility staff failed to ensure that Resident #1 received a physician visit from 3/7/16 to 7/7/16. 5. Facility staff failed to ensure that Resident #10 received a physician recertification for services visit from 7/9/15 to 7/7/16. 6. The facility could not provide documented evidence that Resident #7 was seen by a physician from 7/9/15 through 7/8/16. The findings include: 1. The facility staff failed to provide documentation to evidence Resident #6 was seen by the physician for recertification from 12/30/15 until 6/30/16 (a total of 183 days). Resident #6 was admitted to the facility on 6/26/09. Resident #6's diagnoses included but were not limited to: pain, anxiety and dementia (1). Resident #6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/6/16, coded the	F 387	F387 Continued from Page 77 Resident # 6 was seen by Medical Director on 07/27/16 for recertification visit and documentation is on the medical record. Resident # 8 was seen by Medical Director on 06/18/16 for recertification visit and documentation is on the medical record. Resident # 13 was seen by Medical Director on 07/27/16 for recertification visit and documentation is on the medical record. Resident # 1 no longer resides in the facility. Resident # 10 was seen by Medical Director on 07/27/16 for recertification visit and documentation is on the medical record. Resident # 7 was seen by Medical Director on 06/14/16 for recertification visit and documentation is on the medical record.	

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F 387	Continued From page 78 resident's cognition as being severely impaired. Review of Resident #6's clinical record and copies of physician's progress notes failed to reveal documentation to evidence the resident was seen by the physician for recertification from 12/30/15 until 6/30/16 (a total of 183 days). On 7/7/16 at 10:55 a.m., an interview was conducted with OSM (other staff member) #2 (the medical records employee). OSM #2 stated she gives ASM (administrative staff member) #3 (Resident #6's physician) a list of residents who need to be seen for recertification every week. OSM #2 stated ASM #3 keeps handwritten notes from each visit but doesn't always get the notes typed and on the chart. OSM #2 stated ASM #3 has asked for help regarding this matter and was supposed to receive help the following week. On 7/7/16 at 3:17 p.m., an interview was conducted with ASM #3. ASM #3 stated medical records had been a huge issue. ASM #3 stated he had been asking his bosses for a solid week to "catch up and help to stay caught up." ASM #3 stated his bosses didn't have anyone authorized to assist him until the following week. ASM #3 stated other physicians' notes didn't contain enough information but he (ASM #3) used the review of systems, hand scribbled notes then dictated the notes. ASM #3 stated he was always behind on dictations, especially for routine visits. ASM #3 stated he has an assistant who is supposed to help enter information into the computer but the computer system would not allow his assistant to do so because of HIPAA (2) regulations. ASM #3 was asked to provide his handwritten notes to evidence all of Resident #6's and other residents' physician visits since the last	F 387	F387 Continued from Page 78 **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** A 100% audit of medical records for in-house residents was conducted by HIM director on 07/13/16. A list of residents who had not been seen by a Medical Doctor (MD) within the required 30 days for short stay or 60 days for long stay was compiled and provided to the Interim Executive Director and Medical Director on 07/13/16. The Medical Director or other Credentialed Attending Physician (MD) will complete a recertification visit for each resident identified to be out of compliance as of the audit. These visits will be documented by signed and dated progress note directly in the medical record, completion of Recertification visit form or dictated progress note on the chart within 24 hours of visit. As of 08/05/16, all residents in-house will have a recertification visit within the required time frame documented in the medical record.	

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F 387	Continued From page 79 standard survey. ASM #3 stated, "You can't make sense of my notes." ASM #3 presented his handwritten notes for another resident. On 7/7/16 at 5:25 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the concern regarding physician visits. ASM #1 and ASM #2 were asked to provide all of ASM #3's handwritten notes for Resident #6 and other residents since the last standard survey to evidence the residents had been seen at each required visit. On 7/8/16 at 8:30 a.m., ASM #2 provided a "RESIDENTS LIST" dated 5/30/16 that documented Resident #6 had been seen by the physician on 12/8/15, 2/2/16, 3/29/16 and 5/24/16. No evidence of these visits (including handwritten notes) was provided. At this time, ASM #2 stated she had no further information regarding physician visits. The facility policy titled, "Physician Services Guidelines" documented, "Policy: Documentation in the medical record must reflect supervision of medical care of each resident in the facility. All opinions that require physician judgement are signed and dated only by the physician or his designated representative (i.e., physician's assistant, clinical nurse specialist, or nurse practitioner) per state guidelines...A physician must visit the resident at least every 30 days for the first 90 days after admission and at least every 60 days thereafter. Visits may alternate with a physician's assistant (PA), clinical nurse specialist (CNS) or nurse practitioner (NP). The facility is responsible for investigating any state regulations related to physician delegation to determine if state law is contrary. A visit is	F 387	F387 Continued from Page 79 **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** Health Information Manager (HIM) or HIM assistant will keep a running log of physician visits required and provide MD with recertification visits required for the upcoming week. Beginning on 07/13/16, the HIM director or HIM assistant will complete an audit to determine if required visits from the list are documented in the medical record. A Physician Reminder letter will be provided to the Medical Doctor (MD) of any visits not completed by due date. Visits within 10 days of due date are considered timely. The Medical Director and Interim Executive Director will be provided a copy the list of overdue physician visits weekly beginning on 07/25/2016 for 3 months or until compliance is achieved.	

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F 387	Continued From page 80 considered to be timely if it is made within 10 days after the due date..." No further information was provided prior to exit. (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating..." This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html (2) Health Insurance Portability and Accountability Act (HIPAA) - "Most of us believe that our medical and other health information is private and should be protected, and we want to know who has this information. The Privacy Rule, a Federal law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information. The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written, or oral. The Security Rule is a Federal law that requires security for health information in electronic form." This information was obtained from the website: http://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html 2. Resident #8 was admitted to the facility on 6/27/13 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, chronic back pain and anxiety disorder. On the most recent MDS (minimum data set), an annual assessment dated 6/10/16, Resident #8 was coded as being cognitively intact for making daily	F 387	F387 Continued from Page 80 **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audit regarding any tracking of required physician visits including overdue physicians visits will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by HIM, HIM assistant or Interim Executive Director(IED) for at least 3 months or until 100% compliance is achieved.	08/05/16

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F 387	Continued From page 81 decisions. A review of the clinical revealed evidence of a physician visit made on 7/13/16. During the course of the survey, the facility staff provided evidence of physician visits made on 11/13/15; and 2/23/16 and 6/18/16. However, the staff failed to produce evidence of a physician visit between 7/13/16 and 11/13/15 (120 days); and between 2/23/16 and 6/8/16 (104 days). On 7/7/16 at 3:15 p.m., ASM (administrative staff member) #3, Resident #8's attending physician and the facility medical director, was interviewed. He stated he was aware that he may have been behind on some recertification visits. He stated that he prioritizes his time to see residents with new admissions and acutely ill residents receiving the highest priority. On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. On 7/8/16 at 8:30 a.m., the surveyor was told by ASM #2 that there was no documentation of the above referenced visits by the physician. On 7/8/16 at 10:10 a.m., OSM (other staff member) #2 was interviewed. She stated that she provides the physician a weekly list of visits that need to be made. She stated: "That's all I can do. Everyone knows this is a problem." No further information was provided prior to exit. 3. The physician (per the physician's list of visits)	F 387		

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F 387	Continued From page 82 did not examine Resident # 13 from 12/4/15 until 3/25/16 (a period of 111 days). Resident # 13 was admitted to the facility on 6/20/06 and most recently readmitted on 1/30/15 with diagnoses that included but were not limited to: congestive heart failure, hyperlipidemia, diabetes, multiple sclerosis*, and gastroesophageal reflux disorder. Resident # 13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/1/16, coded Resident # 13 as understood by others and able to understand others. Resident # 13 was coded as scoring 11 of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was moderately cognitively impaired. *Multiple sclerosis (MS) is a disease of the central nervous system. In MS the body's immune system attacks myelin, which coats nerve cells. nccih.nih.gov/health/multiple-sclerosis Review of the clinical record revealed no physician progress notes by the attending physician. During an interview on 7/7/16 at 11:50 a.m. with OSM (other staff member) # 2, OSM # 2 revealed that every week she (OSM # 2) makes a list of all residents that need to be seen by the physician. OSM # 2 stated that she gives the list to the physician each week; OSM # 2 stated that the physician does handwritten notes, then takes the notes and types them up. OSM # 2 further stated that the typed notes don't always get on the chart. During an interview on 7/7/16 at 3:17 p.m. with ASM (administrative staff member) # 3, the	F 387		

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physician, revealed that records are a problem stating, "I've been asking for help for some time to do all the paperwork. I'm getting help next week. I'm always behind in dictation. My hand written notes are not acceptable - what use is a note that you can't read. I recognize that it is a problem. I have handwritten notes for each resident but do not consider my notes a part of the record so I do not date and sign them." ASM # 3 was asked if we could see his notes. ASM # 3 responded that we could.

During the end of day interview on 7/7/16 at 5:30 p.m. with ASM (administrative staff member) # 1, executive director, and ASM # 2, director of nurses, were made aware of the missing physician progress issue. At this time a request was made for the facility policy.

On 7/8/16 at 8:25 a.m. a list of the dates for each visit for each resident was provided by ASM # 1, the executive director. A list of the dates for each visit for each resident was provided. This list documented that ASM # 3 visited Resident # 13 on 12/4/15, 3/25/16, and 5/20/16.

During an interview on 7/8/16 at 8:32 a.m. with ASM # 2, ASM # 2 stated, "I presented everything I have."

No further information was provided prior to exit.

4. Facility staff failed to ensure that Resident #1 received a physician visit from 3/7/16 to 7/7/16.

Resident #1 was admitted to the facility on 2/4/15 and readmitted on 2/1/16 with diagnoses that included but were not limited to: muscle weakness, difficulty swallowing, dementia and

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F 387	Continued From page 84 kidney failure. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 5/18/16 coded the resident as having a 9 out of 15 on the brief interview for mental status indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the clinical record did not evidence documentation of physician notes after 3/7/16 for a total of 121 days since the last physician visit. A request was made to ASM (administrative staff member) #2, the director of nursing, on 7/7/16 for the physician progress notes after 3/7/16 for Resident #10. An interview was conducted on 7/7/16 at 11:00 a.m. with OSM (other staff member) #2, the medical records staff. When asked if the physician's progress notes were to be in the chart, OSM #2 stated that they should. When asked the process she followed to track the physician's visits, OSM #2 stated, "I make a list every week and give it to the doctor." OSM #2 stated that the physician had handwritten notes but had not put them into the computer so the notes were not available in the resident's clinical record. An interview was conducted on 7/7/16 at 3:18 p.m. with ASM #3, the physician. When asked about his notes, ASM #3 stated, "When asking for records it's a huge issue here. I have been asking my bosses to give me a solid week off and then some help to keep up with it. Some doctors	F 387		

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F 387	Continued From page 85 write notes you can't read. I scribble notes as I go along and then dictate my notes; I'm always behind in my dictation. I keep a list of when I see recerts." ASM #3 showed the form that he completes when he examines the residents. When asked if he signed and dated his handwritten notes, ASM #3 stated, "No, because I don't think it's part of the permanent record." When asked if it was acceptable that there were no physician notes on the chart, ASM #3 stated, "No." On 7/7/16 at 5:15 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. On 7/8/16 at 8:30 a.m. ASM #2 stated, "If there is something you didn't get, we don't have it." No physician progress notes were received. Review of the facility's policy titled, "Physician Services Guidelines" documented, "Policy. Documentation in the medical record must reflect supervision of the medical care of each resident in the facility. A physician must visit the resident at least every 30 days for the first 90 days after admission and at least every 60 days thereafter. No further information was provided prior to exit. 5. Facility staff failed to ensure that Resident #10 received a physician recertification for services visit from 7/9/15 to 7/7/16. Resident #10 was admitted to the facility on 1/8/16 with diagnoses that included but were not limited to: arthritis, dementia, high blood	F 387		

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F 387	Continued From page 86 pressure, kidney disease and diabetes. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 4/13/16 coded the resident as having a six out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring the assistance of staff for all activities of daily living. Review of the clinical record did not evidence documentation of a physician re-certification for services note from 7/9/15 to 7/7/16. A request was made to ASM (administrative staff member) #2, the director of nursing, on 7/7/16 for all of the physician progress notes for Resident #10. An interview was conducted on 7/7/16 at 11:00 a.m. with OSM (other staff member) #2, the medical records staff. When asked if the physician's progress notes were to be in the chart, OSM #2 stated that they should. When asked the process she followed to track the physician's visits, OSM #2 stated, "I make a list every week and give it to the doctor." OSM #2 stated that the physician had handwritten notes but had not put them into the computer so the notes were not available in the resident's clinical record. An interview was conducted on 7/7/16 at 3:18 p.m. with ASM #3, the physician. When asked about his notes, ASM #3 stated, "When asking for records it's a huge issue here. I have been asking my bosses to give me a solid week off and then some help to keep up with it. Some doctors	F 387		

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write notes you can't read. I scribble notes as I go along and then dictate my notes; I'm always behind in my dictation. I keep a list of when I see recerts." ASM #3 showed the form that he completes when he examines the residents. When asked if he signed and dated his handwritten notes, ASM #3 stated, "No, because I don't think it's part of the permanent record." When asked if it was acceptable that there were no physician notes on the chart, ASM #3 stated, "No."

On 7/7/16 at 5:15 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

On 7/8/16 at 8:30 a.m. ASM #2 brought the physician's handwritten note dated 3/25 (no year documented). When asked if there were any other notes, ASM #2 stated, "If there is something you didn't get, we don't have it."

Review of the facility's policy titled, "Physician Services Guidelines" documented, "Policy. Documentation in the medical record must reflect supervision of the medical care of each resident in the facility. A physician must visit the resident at least every 30 days for the first 90 days after admission and at least every 60 days thereafter.

No further information was provided prior to exit.

6. The facility could not provide documented evidence that Resident #7 was seen by a physician from 7/9/15 through 7/8/16.

Resident #7 was admitted to the facility on 6/8/15 with diagnoses that included but were not limited to: anxiety, dysuria, high blood pressure, pain,

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F 387	Continued From page 88 dementia, edema, hypothyroid disease, depression, and osteoporosis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/13/16, coded the resident as being severely impaired to make cognitive 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 limited assistance of one staff member. Review of the clinical record did not reveal any physician progress notes since the history and physical dated 6/9/15. There were multiple notes documented by the nurse practitioner throughout the year. The nurse practitioner is employed by the facility. The last documented nurse practitioner note was dated, 4/1/16. An interview was conducted with administrative staff member (ASM) #4, the nurse practitioner, on 7/7/16 at 10:24 a.m. When asked the last time she had seen Resident #7, ASM #4 stated, "If I haven't seen her for a sick call I probably haven't seen her for a while. Hopefully, he (ASM #3 - the physician) saw her and the note just isn't there." When asked if she does the recertification visits, ASM #4 stated, "No, I'm not allowed to do those." An interview was conducted with other staff member (OSM) #2, the medical records employee, on 7/7/16 at 10:59 a.m. When asked who tracks physician visits, OSM #2 stated, "I do." She further expanded stating, "He (physician) has handwritten sheets. He has them in a pile in his office until he puts them in the computer. He has asked for help and it's coming	F 387		

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next week. I have asked and asked for him to do things but I can't make him do something. I've even contacted my corporate person. He takes notes and then doesn't put it in the computer. He's employed by a physician service within our corporation." A request was made to speak with the physician.

An interview was conducted with ASM #3, the physician for Resident #7, on 7/7/16 at 3:20 p.m. ASM #3 stated, "It's a huge issue here. I work for an (name of corporation) affiliate. I wanted a solid week to catch up. They have finally gotten me coverage next week so I can dictate my notes. When someone comes in, I write a handwritten H & P (history and physical) but it's unreadable. I hand scribble notes and then dictate afterwards. I am always behind in dictations. Especially for ones who don't get seen with too many care concerns. I have an assistant who was to help me put them in the computer but they won't allow her to put them in the computer." When asked how he knows who to see, ASM #3 stated, "I have a list of people I see." ASM #3 further stated, "Is this acceptable, no but my notes would be shorter. I want my notes to be readable and have all of the information on them. The routine stuff, I keep a list of recerts (recertification's). The recerts usually are done on Tuesday, Wednesday and Thursday. I run around and scribble a note." When asked if he was aware of the regulations regarding the physician visits and progress notes, ASM #3 stated, "Yes, I am." ASM #3 further stated, "When I do a recert, I look at the medications, lab results, dose reductions. The nurse practitioner cannot do the recerts. When I do the recerts, that's the time I review the nurse practitioner's work." When asked what would happen if

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F 387	Continued From page 90 something happened to him, ASM #3 stated, "It would be a mess but I feel there is enough information that could be used to follow the care. But that's my problem; I want the notes to be more readable and accurate. It's not good. I'm putting together my handwritten notes into the computer for the ones you have requested." On 7/7/16 at 4:46 p.m. ASM #3 brought a list of resident names and handwritten notes of when they were seen. ASM #3 stated, "I do not have any list prior to December." The list documented Resident #7 was seen on 11/28/15, 12/28/15, 2/12/16, 4/14/16, and 6/14/16. ASM #3 was requested to provide the handwritten notes of these visits. The executive director and ASM #2, the director of nursing, were made aware of the above findings on 7/7/16 at 5:28 p.m. A request was made to provide evidence of the physician visits for Resident #7 since last survey. No further information was provided prior to exit.	F 387		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	**F431** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident # 18 was identified in this practice but was not found to be adversely affected by this practice.	

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F 431	Continued From page 91 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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 facility staff failed to secure narcotics on one of six medications carts, the Dogwood unit cart. The facility staff failed to lock the narcotic box during the medication administration observation on 7/7/16 at 8:02 a.m. The findings include: Resident #18 was admitted to the facility on 1/4/15 and readmitted on 7/1/16 with diagnoses that included but were not limited to: clostridium	F 431	F431 Continued from Page 91 Immediately upon notification that the lid on the narcotic drawer of the identified medication cart was malfunctioning causing the drawer not to lock, the Director of Nursing (DON) contacted the pharmacy and a technician was sent out to change out the narcotic box. Repairs were made to the narcotic box on 07/07/16 by a pharmacy technician. On 07/07/16, 1:1 education was provided to LPN # 8 by the Staff Development Coordinator (SDC) regarding the policy that all narcotics must be stored in a double locked system and reporting any problems with the locking mechanisms immediately to the Director of Nursing (DON). **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All residents who are prescribed narcotics have the potential to be affected by this practice.	

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F 431	Continued From page 92 difficile, diabetes, arthritis, high blood pressure and lung disease. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 3/28/16 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. An observation was made on 7/7/16 at 8:32 a.m. of the medication administration to Resident #18 who had requested pain medication. LPN (licensed practical nurse) #8 lifted the lid of the narcotic box, the box was unlocked, and took a hydrocodone* tablet from the narcotic drawer in the medication cart. LPN #8 then closed the lid to the narcotic box and locked the main lock of the cart, leaving the narcotic box unlocked. LPN #8 left the cart and administered the medication to Resident #18. LPN #8 returned to the medication cart, unlocked it, lifted the lid of the narcotic box, removed the medication package and charted that the medication was administered and then closed the lid to the narcotic box. The narcotic box was never locked An interview was conducted on 7/7/16 at 11:45 a.m. with LPN #8. LPN #8 was asked to open the narcotic box on the medication cart. The lid opened without the use of the key. When the lid was pushed down the box would lock. When asked why the narcotic box was usually locked, LPN #8 stated, "Because it's narcotics to keep them safe and so none of the residents can get into them." When asked if the narcotic box should have been left unlocked, LPN #8 stated, "Um, no not really."	F 431	F431 Continued from Page 92 Immediately upon notification of the issue with the identified medication cart, each LPN Unit Manager inspected the other four (4) medication carts to ensure the narcotic drawers were locking properly. No other issues were found. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur?** Beginning on 07/25/16, education will be provided by IED, SDC, and/or DON to all licensed Nurses regarding securement of narcotics in a double locked system. Education will also include how to report issues with the medication carts, including locking mechanisms. Education will be completed by 08/05/16 and same information will be provided to all newly hired nurses. Beginning on 07/25/16, the DON and/or UM will audit each medication cart on their assigned units to ensure narcs are properly secured in a double lock system. This audit will be completed daily for 5 days a week for 4 weeks then 3 times a week for 4 weeks, then once weekly for 4 weeks and results will be documented on an audit form.	

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F 431	Continued From page 93 An interview was conducted on 7/7/16 at 11:55 a.m. with LPN #2, the unit manager. LPN #2 was shown the unlocked narcotic box. When asked why the narcotic box had a lock on it, LPN #2 stated, "That's what we are supposed to do because it has controlled substances in it." On 7/7/16 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "Medication Storage & Security in the Facility" documented, "NOTE: Scheduled II narcotic medications.....Medications are then double locked as required. No further information was provided prior to exit. *Hydrocodone is used to relieve severe pain. <https://www.nlm.nih.gov/medlineplus/medlineplus.html>	F 431	**Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of Medication Cart Audit including verification that all locks are functioning properly will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON or UM for 3 months or until 100% compliance is achieved.	08/05/16
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	**F441 – Part 1 – Resident # 28** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident # 28 was identified as being affected by this practice. The nurse that gave resident # 28 medication without washing her hands prior to preparation	

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F 441	Continued From page 94 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that facility staff failed to follow infection control practices for two of 28 residents in the survey sample. a. The facility staff failed to wash their hands before and after medication administration for Resident #18 and Resident #28 and failed to sanitize the inhaler used by Resident #18. b. The facility staff was observed sitting on	F 441	F441 Continued from Page 94 or after administration of the Medication was provided re-education by the Staff Development RN/Infection Control Nurse (SDC) regarding proper hand washing and infection control methods to use during medication administration on 07/07/16. On 07/07/16, Five (5) random observations of medication administration were completed by the SDC/Infection control Nurse to ensure proper hand washing practice and infection control methods were being utilized during medication pass. No other issues were identified. **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All residents residing in the facility have the potential to be affected by this practice.	

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F 441	Continued From page 95 Resident #18's bed. Resident #18 was on contact isolation for clostridium difficile (c-diff).* The findings include: a. Resident #18 was admitted to the facility on 1/4/15 and readmitted on 7/1/16 with diagnoses that included but were not limited to: clostridium difficile*, diabetes, arthritis, high blood pressure and lung disease. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 3/28/16 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living. The resident was coded as always being continent of bowel and bladder. Resident #28 was admitted to the facility on 12/17/12 with diagnoses that included but were not limited to: elevated cholesterol, dementia and anxiety. The most recent MDS, a quarterly assessment, with an ARD of 6/1/16 coded the resident as sometimes understanding and sometimes making self understood. Resident #28 was coded as 00 out of 15 on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. An observation of the medication administration was made on 7/7/16 at 8:02 a.m. with LPN (licensed practical nurse) #8. LPN #8 prepared	F 441	F441 Continued from Page 95 The SDC began performing 1:1 medication pass observations on 07/07/16 to ensure that staff wore gloves when residents are on isolation precautions and that Licensed Nurses completed hand washing before and after each medication pass. No other issues were identified. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** The Director of Nursing (DON) and/ or Staff Development/Infection Control Nurse (SDC) began education to all licensed nurses and Certified Nursing Assistants (C.N.A.) on 07/07/16 regarding infection control with emphasis on medication administration and proper hand washing. This education will be completed by 08/05/16 and will also be provided to all new hires.	

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F 441	Continued From page 96 the medications for Resident #28 without first washing her hands. The medications were crushed and put into applesauce. LPN #8 fed the medicine to the resident and then gave her some water from the cup at the resident's bedside. LPN #8 returned to the medication cart, took out the residents packages of medication and documented that the medications had been given. LPN #8 did not wash her hands. LPN #8 then prepared the medications including an inhaler for Resident #18 and took them into the resident's room. At this time, gowns and gloves were observed in Resident #18's room. LPN #8 put on a pair of gloves and Resident #18 used the Advair** inhaler with her bare hands and gave it back to LPN #8. LPN #8 gave the resident the rest of her medications, removed her gloves and picked up the inhaler and returned it to the medication cart containing other residents ' medications. LPN #8 did not wash her hands after administering the medications or sanitize the inhaler prior to returning it to the medication cart. A review of Resident #18s physician ' orders dated 7/1/16 documented, "Advair Diskus 250 mcg (microgram) -50 mcg/dose powder for inhalation. Per Inhaler BID (twice a day) 1 puff by inhalation BID for SOB (shortness of breath). " Review of the July 2016 medication administration record documented that the resident had received the Advair twice a day on 7/1-7/4/16 and 7/6-7/7/16. A review of Resident #18 ' s physician ' s orders dated 7/4/16 documented, " Contact Isolation for C-Diff. " A review of the resident ' s care plan initiated on	F 441	F441 Continued from Page 96 The DON or SDC will maintain a log of all infections, and track and trend monthly for education/re-education opportunities for staff. All newly hired licensed nurses will be educated on same topics and given competencies for medication pass and infection control upon hire, annually, and as needed. The DON, SDC or Nurse Unit Manager (UM) will observe and audit hand washing and infection control procedures during medication administration 5 times a week) x 4 weeks then 3 Times a week for 4 weeks, then weekly x 4 weeks. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of Infection Control and Hand washing audits during Medication Administration will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON, SDC or UM for 3 months or until 100% compliance is achieved.	08/05/16

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F 441	Continued From page 97 7/4/16 documented, " PROBLEM Resident has diagnosis of Clostridium difficile, (C-Diff-Toxin). " There was no evidence of documentation related to contact isolation. An interview was conducted on 7/7/16 at 11:45 a.m. with LPN #8, regarding when staff washed their hands. LPN #8 stated, "After every resident." When asked if she had washed her hands before and after administering the medications to Resident #28 and Resident #18, LPN #8 stated, "No." When asked why there were gowns and gloves in Resident #18's room, LPN #8 stated she didn't know. When asked if she knew Resident #18 was on contact isolation, LPN #8 stated she did not. When asked what precautions she would use with a resident with c-diff infection, LPN #8 stated, "Put gown on and gloves. Then wash your hands with soap and water and use (name of hand sanitizer) as well." When asked what process staff followed when returning an inhaler used by the resident to the medication cart, LPN #8 stated, "Probably clean it off. Anything coming out of the room should be cleaned." When asked why she would do that, LPN #8 stated, "For infection control." An interview was conducted on 7/7/16 at 12:00 p.m. with LPN #2. When asked what infection control practices staff used when administering medications, LPN #2 stated, "Handwashing." When asked what process staff followed when returning an inhaler used by a resident, LPN #2 stated, "It should be wiped down." When asked why, LPN #2 stated, "To prevent the spread of infection." An interview was conducted on 7/7/16 at 1:00 p.m. with RN (registered nurse) #1, the infection	F 441	F441 Continued from Page 97 **F441 –** **2.) Resident # 18** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident # 18 was identified as being affected by this practice. The nurse that gave resident # 18 medication was provided re-education by the Staff Development RN/Infection Control RN (SDC). This education contained proper hand washing and infection control methods to use during medication administration. The same nurse was also educated on isolation precautions and how residents on contact isolation should be identified. The C.N.A. that was identified to be sitting on the bed while assisting resident # 18 was educated on isolation precautions and infection control.	

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F 441	Continued From page 98 control nurse. When asked when staff should wash their hands, RN #1 stated, "Going into the room they use hand sanitizer going out of the room use hand sanitizer and after any personal care have to use the sanitizer. When asked why staff needed to wash their hands, RN #1 stated, "So bacterial diseases don't get spread from resident to resident." Review of the facility's policy titled, "Policies for Medication Administration" documented, "Procedure. 1. Follow hand hygiene protocol before and after each administration of medication." Review of the facility's policy titled, "Hand Hygiene" documented, "Purpose. To decrease the risk of transmission of infection by appropriate hand hygiene. Policy. Handwashing/hand hygiene is generally considered the most important single procedure of preventing nosocomial infections. Note: Because alcohol-based hand rubs do not kill spore-forming organism, they should not be used by staff when caring for residents with infections caused by spore-forming organisms. Example are Clostridium difficile...." On 7/7/16 at 5:15 p.m. ASM #1 (administrative staff member), the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. *Clostridium difficile (C. difficile) is a bacterium that causes diarrhea and more serious intestinal conditions such as colitis. Symptoms include: Watery diarrhea (at least three bowel movements per day for two or more days), Fever, Loss of	F 441	F441 Continued from Page 98 **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All residents residing in the facility have the potential to be affected by this practice. Isolation carts are placed inside the resident room for those identified on contact or droplet precautions and resident on isolation precautions are listed on alert charting sheet. An audit of all residents with current contact isolation precautions was compiled by the SDC on 07/27/2016 and each room was verified to contain an isolation cart as well as a magnetic sign on the door face that says "Stop - see nurse prior to entering room". No other issues were found. On 07/07/16, the Director of Nursing (DON), Unit Managers (UM) and/or SDC/Infection Control Nurse began random observations of C.N.A.'s providing resident care to ensure no C.N.A.'s were sitting on resident beds and that they were following infection control methods while providing care to resident's on isolation precautions.	

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F 441	Continued From page 99 appetite, Nausea, Abdominal pain or tenderness. <https://www.nlm.nih.gov/medlineplus/clostridiumdifficileinfections.html> ** 1.2 Maintenance Treatment of Chronic Obstructive Pulmonary Disease. ADVAIR DISKUS 250/50 is indicated for the twice-daily maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema. <https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=f53cb2d5-3267-401e-9393-dff8357830dd> b. An observation was made on 7/6/16 at 3:55 p.m. of CNA (certified nursing assistant) #7 sitting on the foot of Resident #18's bed without a gown or gloves on. The resident was sitting in a wheelchair next to the bed. CNA #7 left the room caring a plastic trash bag without washing her hands. An interview was conducted on 7/7/16 at 1:00 p.m. with RN #1, the infection control nurse. When asked if staff should sit on the bed of a resident with a c-diff infection, RN #1 stated, "No." When asked why, RN #1 stated, "Because that's where they go to bed and sleep. The spores have a high chance of being on the bed." An interview was conducted on 7/7/16 at 2:40 p.m. with CNA #4. When asked what process staff followed when going into Resident #18's room, CNA #4 stated, "Gown, glove and wash hands with soap and water. Don't sit on the bed." When asked why staff should not sit on the bed, CNA #4 stated, "It may have BM (bowel movement) on the bed and you would get it on	F 441	F441 Continued from Page 99 **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** The Director of Nursing (DON) and/ or Staff Development/Infection Control Nurse (SDC) began education to all licensed nurses and certified nursing assistants (C.N.A.) on 07/07/2016 regarding infection control including proper hand washing and isolation precautions. This education will be completed by 08/05/2016 and will also be provided to all new hires. The DON or SDC will maintain a log of all infections, and track and trend monthly for education/re-education opportunities for staff. All newly hired licensed nurses will be educated on same topics and given competencies for isolation precaution identification, medication pass and infection control upon hire, annually, and as needed. All newly hired C.N.A.'s will be educated on infection control program including isolation precautions, upon hire, annually, and as needed.	

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F 441	Continued From page 100 your clothes and you could take it to the next room." An interview was conducted on 7/7/16 at 4:10 p.m. with CNA #7. When asked if staff should sit on the bed of a resident with a c-diff infection, CNA #7 stated, "I sat for a moment to label her things. I shouldn't have." When asked why she shouldn't sit on the bed, CNA #7 stated, "It's dirty. It could get on my clothes, I could take it home and I could spread it to the other residents." Review of the facility's policy titled, "Clostridium Difficile" documented, "Purpose. to minimize the transmission of Clostridium difficile (C-Diff) within the facility. Contact Precautions: Gloves are worn to enter the room of a resident who has diarrhea caused by C. difficile. A gown is needed to enter the room of a resident who had diarrhea caused by C. difficile if substantial contact with the resident or environmental surfaces is anticipated. Gowns and gloves are removed before leaving the resident's room and hands must be washed following hand hygiene guidelines." On 7/7/16 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was obtained prior to exit.	F 441	F441 Continued from Page 100 The DON, SDC or Nurse Unit Manager (UM) will perform observations for residents on isolation precautions to ensure proper hand washing and infection control procedures during resident care are being followed. These observations will occur 5 times a week x 4 weeks then 3 times a week for 4 weeks, then weekly x 4 weeks. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of infection control, hand washing and isolation precaution audits will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON, SDC, or UM for 3 months or until 100% compliance is achieved.	08/05/16
F 502 SS=E	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502	**F502** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?**	

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F 502	Continued From page 101 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 obtain physician ordered laboratory tests for 3 of 28 residents in the survey sample, Residents #6, #8, and #7. 1. a. The facility staff failed to obtain a physician ordered fasting lipid panel test and liver function test for Resident #6 in December 2015. 1. b. The facility staff failed to obtain a physician ordered thyroid stimulating hormone level for Resident #6 ordered on 3/8/16. 1. c. The facility staff failed to obtain a physician ordered liver function test for Resident #6 in June 2016. 2. The facility staff failed to perform a stool sample laboratory test ordered for Resident #8 on 4/19/16. 3. The facility staff failed to complete a liver function panel blood test in December 2015, per the physician order, for Resident #7. The findings include: 1. a. The facility staff failed to obtain a physician ordered fasting lipid panel test (1) and liver function test (2) for Resident #6 in December 2015. Resident #6 was admitted to the facility on 6/26/09. Resident #6's diagnoses included but were not limited to: pain, anxiety and dementia (3). Resident #6's most recent MDS (minimum	F 502	F502 Continued from Page 101 Resident's # 6, #8 and #7 were identified in this practice. 1. Resident # 6's physician was notified on 07/12/16 of ordered fasting lipid panel test and liver function test from December 2015 not being collected as ordered. A new order was written on 07/14/16 to perform fasting lipid panel test and liver function test. Resident was not adversely affected by not having blood work performed in December 2015. 2. Resident # 6's physician was notified on 07/08/16 of ordered thyroid stimulating hormone level test ordered on 03/08/16 not being collected as ordered. The order was discontinued and not rewritten. Resident was not adversely affected by not having blood work performed. 3. Resident # 6's physician was notified of ordered fasting liver function test from June 2016 not being collected as ordered. A new order was written on 07/14/16 to perform fasting liver function test. Resident was not adversely affected by not having blood work performed in June 2016.	

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F 502	Continued From page 102 data set), a quarterly assessment with an ARD (assessment reference date) of 4/6/16, coded the resident's cognition as being severely impaired. Review of Resident #6's clinical record revealed a physician's order summary signed by the physician on 7/1/16 that documented an order dated 9/19/15 for a fasting lipid panel and liver function test every six months in June and December. Further review of Resident #6's clinical record failed to reveal results of a fasting lipid panel or liver function test for December 2015. Resident #6's comprehensive care plan with an onset date of 1/15/15 failed to document information regarding the above lab tests. On 7/7/16 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the unit manager). LPN #3 stated the above requested labs could not be found and were not documented on the "lab sheet." LPN #3 was asked the facility process for obtaining physician ordered labs. LPN #3 stated nurses have lab books on each unit. LPN #3 stated nurses put the lab order in the lab book and the unit manager writes up lab sheets for the following day. LPN #3 stated the lab books contain a lab login sheet to document residents' names, room numbers, labs ordered, dates and a place for the lab personnel to initial the date the labs are obtained and the location where the blood is drawn. LPN #3 stated after labs are obtained and taken to the laboratory, the results are faxed to the facility and reviewed by the physician. On 7/7/16 at 5:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the	F 502	F502 Continued from Page 102 4. Resident # 8's physician was notified on 07/08/16 that a stool sample laboratory test ordered on 04/19/16 was not obtained as ordered. Order was discontinued on 07/08/16. Resident was not adversely affected by not having the stool sample lab test completed. 5. Resident # 7's physician was notified of ordered liver function panel blood test from December 2015 not being collected as ordered. The liver function panel test from December 2015 was discontinued on 07/18/16. Liver function panel test had been performed on 06/08/16. Resident was not adversely affected by not having December 2015 blood work performed. **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All residents who have laboratory tests orders have the potential to be affected by this practice.	

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F 502	Continued From page 103 director of nursing) were made aware of the above findings. The facility policy titled, "Laboratory Order Sheet" documented, "Standard: All laboratory work is ordered on a standardized laboratory order sheet to minimize errors and omissions. Policy: Department of nursing follows the laboratory order sheet policy. All laboratory work is ordered using the standardized two-ply laboratory order sheet. Laboratory order sheet is labeled with resident data information. Laboratory order sheet is placed in a consistent area for pickup by laboratory personnel. The carbon copy of the completed laboratory order sheet is discarded after the laboratory interim report is received. Procedure: 1. Unit secretary or nurse completes the necessary information on the laboratory order sheet. 2. Unit secretary or nurse checks the appropriate space in front of the correct test. If the ordered laboratory work is not listed on the laboratory order sheet, the test(s) are written in the 'additional tests' section. 3. The carbon is then removed and placed in the front pocket of the notebook for interim laboratory reports. It is discarded only after the interim laboratory report has been received. 4. The completed original laboratory order sheet is placed in plastic bag with the specimen and then placed in a consistent area for pickup by lab personnel..." No further information was presented prior to exit.	F 502	F502 Continued from Page 103 A 100% audit of all labs ordered for in-house residents and due since December 2015 was completed on 07/18/2016 by the Unit Managers (UM). Any laboratory test discovered during the audit to not be completed was discussed with the Nurse Practitioner or Medical Director. New orders were written as needed. This process was completed on 07/18/16. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** Starting 07/25/16, education will be provided by the IED, DON, and/or SDC to all Licensed Nurses regarding proper procedures for ordering labs by use of laboratory books on each nurse's	

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F 502	Continued From page 104 (1) "The lipid profile (fasting lipid panel) is used as part of a cardiac risk assessment to help determine an individual's risk of heart disease and to help make decisions about what treatment may be best if there is borderline or high risk." This information was obtained from the website: https://labtestsonline.org/understanding/analytes/lipid/tab/test (2) "A liver panel (liver function test) may be used to screen for liver damage, especially if someone has a condition or is taking a drug that may affect the liver." This information was obtained from the website: https://labtestsonline.org/understanding/analytes/liver-panel/tab/test (3) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating..." This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html 1. b. The facility staff failed to obtain a physician ordered thyroid stimulating hormone level (1) for Resident #6 ordered on 3/8/16. Review of Resident #6's clinical record revealed a physician's order dated 3/8/16 for a thyroid stimulating hormone level in addition to other lab tests to be completed on 3/15/16. Further review of Resident #6's clinical record revealed the results of the additional lab tests dated 3/15/16 but failed to reveal results of a thyroid stimulating hormone level.	F 502	F502 Continued from Page 104 station. The education will include that if a sample is unable to be obtained in the timeframe ordered, that order should be discontinued and a new clarified order should be received from the NP or MD. On 07/26/16, the LPN Unit Managers (UM) were educated on the process of writing up lab slips, verifying that all lab tests were collected as ordered and that results were received, reviewed by the NP or MD and placed in the medical record. Education will be completed by 08/05/16. The LPN Unit Mangers (UM) or DON will audit all laboratory orders and results daily, Monday through Friday to ensure all laboratory tests were performed as ordered for at least 3 months. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audits for documentation of laboratory test completed as ordered will be reported	

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F 502	Continued From page 105 Resident #6's comprehensive care plan with an onset date of 1/15/15 failed to document information regarding the above lab test. On 7/7/16 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the unit manager). LPN #3 stated the above requested lab could not be found and was not documented on the "lab sheet." LPN #3 was asked the facility process for obtaining physician ordered labs. LPN #3 stated nurses have lab books on each unit. LPN #3 stated nurses put the lab order in the lab book and the unit manager writes up lab sheets for the following day. LPN #3 stated the lab books contain a lab login sheet to document residents' names, room numbers, labs ordered, dates and a place for the lab personnel to initial the date the labs are obtained and the location where the blood is drawn. LPN #3 stated after labs are obtained and taken to the laboratory, the results are faxed to the facility and reviewed by the physician. On 7/7/16 at 5:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. No further information was provided prior to exit. (1) "The thyroid-stimulating hormone (TSH) test is often the test of choice for evaluating thyroid function and/or symptoms of a thyroid disorder, including hyperthyroidism or hypothyroidism." This information was obtained from the website: https://labtestsonline.org/understanding/analytes/tsh/tab/test 1. c. The facility staff failed to obtain a physician	F 502	F502 Continued from Page 105 for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON, SDC or UM for 3 months or until 100% compliance is achieved.	08/05/16

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F 502	Continued From page 106 ordered liver function test (1) for Resident #6 in June 2016. Review of Resident #6's clinical record revealed a physician's order summary signed by the physician on 7/1/16 that documented an order dated 9/19/15 for a fasting lipid panel and liver function test every six months in June and December. Further review of Resident #6's clinical record failed to reveal results of a liver function test for June 2016. Resident #6's comprehensive care plan with an onset date of 1/15/15 failed to document information regarding the above lab test. On 7/7/16 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the unit manager). LPN #3 stated the above requested lab could not be found and was not documented on the "lab sheet." LPN #3 was asked the facility process for obtaining physician ordered labs. LPN #3 stated nurses have lab books on each unit. LPN #3 stated nurses put the lab order in the lab book and the unit manager writes up lab sheets for the following day. LPN #3 stated the lab books contain a lab login sheet to document residents' names, room numbers, labs ordered, dates and a place for the lab personnel to initial the date the labs are obtained and the location where the blood is drawn. LPN #3 stated after labs are obtained and taken to the laboratory, the results are faxed to the facility and reviewed by the physician. On 7/7/16 at 5:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.	F 502		

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F 502	Continued From page 107 No further information was provided prior to exit. (1) "A liver panel (liver function test) may be used to screen for liver damage, especially if someone has a condition or is taking a drug that may affect the liver." This information was obtained from the website: https://labtestsonline.org/understanding/analytes/liver-panel/tab/test 2. Resident #8 was admitted to the facility on 6/27/13 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, chronic back pain and anxiety disorder. On the most recent MDS (minimum data set), an annual assessment dated 6/10/16, Resident #8 was coded as being cognitively intact for making daily decisions. A review of Resident #8's clinical record revealed the following order written 4/19/16: "Collect stool sample (fecal culture) (1) to r/o (rule out) C-diff (Clostridium difficile bacteria) (2) and Norovirus (3)." Further review of the record (including laboratory results and nurses notes) revealed no evidence that this test was ever performed for Resident #8. A review of Resident #8's comprehensive care plan dated 3/23/15 revealed no information related to laboratory tests. On 7/7/16 at 1:25 p.m., LPN #3, a unit manager, was interviewed regarding these missing laboratory test results. She stated: "If the stool was formed (not runny), we would not have sent it. But I can't find any documentation for this	F 502		

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F 502	Continued From page 108	F 502		

resident on that day." When asked about the process for obtaining a laboratory test for a resident, she stated the nurse takes the order and writes it in the lab book. She stated that for a stool sample, the facility staff collects the sample and places it in the lab refrigerator, where the lab personnel pick it up on the next lab day. When asked who is responsible for checking to make sure all ordered lab tests have been performed, she stated: "Unit managers should be checking back to make sure it was done."

On 7/7/16 at 5:30 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)"A fecal culture is a laboratory test to find organisms in the stool (feces) that can cause gastrointestinal symptoms and disease." This information is taken from the website https://www.nlm.nih.gov/medlineplus/ency/article/003758.htm.
(2)"Clostridium difficile (C. difficile) is a bacterium that causes diarrhea and more serious intestinal conditions such as colitis." This information is taken from the website https://www.nlm.nih.gov/medlineplus/clostridiumdifficileinfections.html.
(3)"Noroviruses are a group of related viruses. Infection with these viruses causes an illness called gastroenteritis, an inflammation of the stomach and intestines. It can spread from person to person, or through contaminated food or water. You can also get it if you touch a contaminated surface. Norovirus can be serious, especially for young children and older adults."

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F 502	Continued From page 109 This information is taken from the website https://www.nlm.nih.gov/medlineplus/norovirusinfections.html. 3. The facility staff failed to complete a liver function panel blood test in December 2015, per the physician order, for Resident #7. Resident #7 was admitted to the facility on 6/8/15 with diagnoses that included but were not limited to: anxiety, dysuria, high blood pressure, pain, dementia, edema, hypothyroid disease, depression, and osteoporosis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/13/16, coded the resident as being severely impaired to make cognitive 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 limited assistance of one staff member. The "Physician Orders July 2016" documented, "FLP (fasting lipid panel) (1), LFT (liver function test) (2), TSH (thyroid stimulating hormone) (3) every 6 months JUNE - DEC (December) every 6 months." This order was originally written on 10/4/15. Review of the clinical record revealed a FLP and TSH test results dated, 12/1/15. There were no LFT test results. An interview was conducted with LPN (licensed practical nurse) #2, the unit manager, on 7/7/16 at 9:58 a.m. The physician order and test results above were reviewed with LPN #2. LPN #2 verified that there were no results for the LFT	F 502		

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F 502	Continued From page 110 results in the clinical record. On 7/7/16 at 11:01 a.m. LPN #2 informed this surveyor that the LFT test results were not done in December 2015. An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 7/7/16 at 12:33 p.m. When asked if a physician orders a laboratory test, should it be completed, "ASM #2 stated, "It will be obtained unless if unable to attend or resident refuses, then the physician is to be notified." An interview was conducted with LPN #3, a unit manager, on 7/7/16 at 1:31 p.m. When asked the process for obtaining laboratory tests, LPN #3 stated, "You have to have a physician's order for them. Then they are to be completed per the order. If unable to obtain them you have to notify the doctor." When asked how they ensure that all laboratory tests are done per the physician order, LPN #3 stated, "We are to mark them off." When asked who marks them off, LPN #3 stated, "The unit manager is responsible for checking that they were done." The executive director and ASM #2 were made aware of the above findings on 7/7/16 at 5:38 p.m. No further information was provided prior to exit.	F 502		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician.	F 504	**F504** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?**	

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F 504	Continued From page 111 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 obtain a physician's order for a laboratory test for one of 28 residents in the survey sample, Resident #11. The facility staff failed to obtain a physician's order for a hemoglobin A1C (1) obtained from Resident #11 on 1/12/16. The findings include: Resident #11 was admitted to the facility on 9/19/14. Resident #11's diagnoses included but were not limited to: chronic kidney disease, high blood pressure and pain. Resident #11's most recent MDS (minimum data set), a significant change in status assessment, with an ARD (assessment reference date) of 6/17/16, coded the resident's cognition as moderately impaired. Review of Resident #11's clinical record revealed a physician's order dated 1/5/16 for a BMP (basic metabolic panel (2)) on 1/12/16. An order for a hemoglobin A1C on 1/12/16 was not documented. Further review of Resident #11's clinical record revealed the results of a BMP obtained on 1/12/16 and a hemoglobin A1C obtained on 1/12/16. Resident #11's comprehensive care plan with an onset date of 1/5/15 documented, "Resident is at risk for complications associated with hyper or	F 504	F504 Continued from Page 111 Resident # 11 was identified in this practice. 07/08/16, resident # 11's physician was notified of additional blood test, A1C being obtained on 01/12/16 while an ordered BMP was completed as ordered. No new orders were received at that time. Resident was not adversely affected by having additional blood work performed. **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All residents who have laboratory tests orders have the potential to be affected by this practice. A 100% lab audit for lab tests ordered and due since December 2015 was completed on 07/18/16 by the Unit Managers (UM). No other occurrences of laboratory tests being obtained without an order were identified.	

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F 504	Continued From page 112 hypoglycemia (high or low blood sugar)...Approaches: Monitor labs (laboratory tests) as indicated and report results...Resident is at risk for alteration in fluid balance...Labs as ordered and report results..." On 7/7/16 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the unit manager). LPN #3 was asked the facility process for obtaining physician ordered labs. LPN #3 stated nurses have lab books on each unit. LPN #3 stated nurses put the lab order in the lab book and the unit manager writes up lab sheets for the following day. LPN #3 stated the lab books contain a lab login sheet to document residents' names, room numbers, labs ordered, dates and a place for the lab personnel to initial the date the labs are obtained and the location where the blood is drawn. LPN #3 stated after labs are obtained and taken to the laboratory, the results are faxed to the facility and reviewed by the physician. LPN #3 was asked if the facility staff had to have a physician's order to obtain a lab test. LPN #3 stated, "We don't do labs without an order." LPN #3 stated the hemoglobin A1C obtained from Resident #6 on 1/12/16 wasn't documented to be obtained on the lab sheet or communicated in information given to the laboratory. On 7/7/16 at 5:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility policy titled, "Laboratory Order Sheet" documented, "Standard: All laboratory work is ordered on a standardized laboratory order sheet to minimize errors and omissions.	F 504	F504 Continued from Page 112 **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur?** Starting 07/25/16, education will be provided by the IED, DON, and/or SDC to all Licensed Nurses regarding proper procedures for ordering labs by use of laboratory books on each nurse's station. The LPN Unit Managers were educated on the process of writing up lab slips, verifying that all ordered labs were collected as ordered in a timely manner and that results were received as ordered, reviewed by the NP or MD and placed in the medical record. The education will include that if an additional laboratory test result is received, the NP or MD should be consulted upon receipt of results. Clarification orders will be obtained if NP or MD verbally added an additional lab request after the specimen was delivered to lab. If there is no evidence that test was ordered after physician	

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F 504	Continued From page 113 Policy: Department of nursing follows the laboratory order sheet policy. All laboratory work is ordered using the standardized two-ply laboratory order sheet. Laboratory order sheet is labeled with resident data information. Laboratory order sheet is placed in a consistent area for pickup by laboratory personnel. The carbon copy of the completed laboratory order sheet is discarded after the laboratory interim report is received. Procedure: 1. Unit secretary or nurse completes the necessary information on the laboratory order sheet. 2. Unit secretary or nurse checks the appropriate space in front of the correct test. If the ordered laboratory work is not listed on the laboratory order sheet, the test(s) are written in the 'additional tests' section. 3. The carbon is then removed and placed in the front pocket of the notebook for interim laboratory reports. It is discarded only after the interim laboratory report has been received. 4. The completed original laboratory order sheet is placed in plastic bag with the specimen and then placed in a consistent area for pickup by lab personnel..." No further information was presented prior to exit. (1) "A1C is a blood test for type 2 diabetes and prediabetes. It measures your average blood glucose, or blood sugar, level over the past 3 months..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-	F 504	F504 Continued from Page 113 review, the laboratory will be notified immediately regarding the discrepancy to determine why the test was performed. Education will be completed by 08/05/2016. The LPN Unit Mangers (UM) or DON will audit all laboratory orders and results daily, Monday through Friday to ensure all laboratory tests were performed as ordered for at least 3 months. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audits for documentation of laboratory test completed as ordered will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON, SDC or UM for 3 months or until 100% compliance is achieved.	08/05/16

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F 504	Continued From page 114 meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=hemoglobin+a1c&_ga=1.187670888.1308579129.1468338746 (2) BMP (basic metabolic panel) - "A 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. The tests provide information about your body's chemical balance and metabolism. They can give doctors information about your muscles (including the heart), bones, and organs, such as the kidneys and liver." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=bmp	F 504		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that	F 514	**F514** **Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident's # 11, #3, #4, #8, #2, # 12, # 13, # 10 and # 9 were listed as being affected by this practice. 1. Resident # 11 – Notes from visits on: 07/24/15, 09/22/15, 11/27/15, 01/28/16, 04/06/16 were dictated on 07/07/16 and placed in medical record on 07/07/16.	

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F 514	Continued From page 115 the facility staff failed to maintain a complete and accurate clinical record for 9 of 28 residents in the survey sample, Residents #11, #3, #4, #8, #2, #12, #13, #10 and #9. 1. The facility staff failed to ensure Resident #11's clinical record contained physician's progress notes for visits that occurred on 7/24/15, 9/22/15, 11/27/15, 1/28/16 and 4/6/16. 2. a. The facility failed to document circumstances surrounding Resident #3's transfer to the emergency room on 6/30/16. b. The facility staff failed to include a record of physician visits for Resident #3 on the clinical record. 3. The facility staff failed to include a record of physician visits for Resident #4 on the clinical record. 4. The facility staff failed to include a record of physician visits for Resident #8 on the clinical record. 5. Resident # 2 did not have copies of the physician progress notes for 2/9/16, 2/29/16, 3/5/16, 4/1/16, 4/29/16, and 5/27/16 on the clinical record. 6. Resident # 12 did not have copies of the physician progress notes for 12/4/15, 1/29/16, 3/25/16, and 5/20/16 on the clinical record. 7. Resident # 13 did not have copies of the physician progress notes for 12/4/15, 3/25/16, and 5/20/16 on the clinical record.	F 514	F514 Continued from Page 115 2. Resident # 3 a.) Transfer to ER – nurse who did not complete documentation regarding events of emergency room transfer on 06/30/16 received 1:1 education by the DON on 07/26/2016. b.) Handwritten notes for physician visits on 03/30/16 and 06/16/16 were signed and dated by the Medical Director and were placed on the medical record on 07/26/16. 3. Resident # 4 – Handwritten notes for physician visits on 03/19/16, 04/15/16, 05/27/16 and 07/01/16 were signed and dated by the Medical Director and placed on medical record on 07/26/16. 4. Resident # 8 – Handwritten notes for physician visits on 11/13/15, 01/08/16, 02/23/16, 06/18/16 were signed and dated by the Medical Director and placed on the medical record on 07/26/16.	

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F 514	Continued From page 116 8. The facility staff failed to include a record of physician visits for Resident #10 on the clinical record. 9. There were no physician progress notes in the clinical record for Resident #9 since 12/7/15. The findings include: 1. The facility staff failed to ensure Resident #11's clinical record contained physician's progress notes for visits that occurred on 7/24/15, 9/22/15, 11/27/15, 1/28/16 and 4/6/16. Resident #11 was admitted to the facility on 9/19/14. Resident #11's diagnoses included but were not limited to: chronic kidney disease, high blood pressure and pain. Resident #11's most recent MDS (minimum data set), a significant change in status assessment, with an ARD (assessment reference date) of 6/17/16, coded the resident's cognition as moderately impaired. Review of Resident #11's clinical record failed to reveal physician recertification progress notes for each required visit during the time period of 7/24/15 through 4/6/16. On 7/7/16 at 11:15 a.m., ASM (administrative staff member) #2 (the director of nursing) confirmed Resident #11's physician's recertification progress notes were not in the clinical record and had to be printed out. Review of Resident #11's printed physician's recertification notes revealed the resident was seen by the physician on 7/24/15, 9/22/15, 11/27/15, 1/28/16 and 4/6/16; however, the printed notes were not electronically signed by the	F 514	F514 Continued from Page 116 5. Resident # 2 - Handwritten and dictated notes for physician visits on 02/01/16, 02/09/16, 02/29/16, 03/05/16, 04/01/16, 04/21/16, 04/29/16, 05/27/16 and 07/06/16 were signed and dated by the Medical Director or Nurse Practitioner and placed on the medical record on 07/26/16. 6. Resident # 12 - Handwritten and dictated notes for physician visits on 12/04/15, 01/29/16, 03/25/16, 03/26/16, 05/20/16 and 05/27/16 were signed and dated by the Medical Director or Nurse Practitioner and placed on the medical record on 07/26/16. 7. Resident # 13 - Handwritten and dictated notes for physician visits on 12/04/15, 12/08/15, 02/23/16, 03/25/16, 05/20/16, 05/24/16, and 07/27/16 were signed and dated by the Medical Director or Nurse Practitioner and placed on the medical record on 07/27/16.	

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F 514	Continued From page 117 physician until 7/7/16. On 7/7/16 at 10:55 a.m., an interview was conducted with OSM (other staff member) #2 (the medical records employee). OSM #2 stated she gives ASM (administrative staff member) #3 (Resident #11's physician) a list of residents who need to be seen for recertification every week. OSM #2 stated ASM #3 keeps handwritten notes from each visit but doesn't always get the notes typed and on the chart. OSM #2 stated ASM #3 has asked for help regarding this matter and was supposed to receive help the following week. On 7/7/16 at 3:17 p.m., an interview was conducted with ASM #3. ASM #3 stated medical records had been a huge issue. ASM #3 stated he had been asking his bosses for a solid week to "catch up and help to stay caught up." ASM #3 stated his bosses didn't have anyone authorized to assist him until the following week. ASM #3 stated other physicians' notes didn't contain enough information but he (ASM #3) used the review of systems, hand scribbled notes then dictated the notes. ASM #3 stated his handwritten notes were for his personal use to dictate his typed notes. When asked if his handwritten notes were signed, dated and placed on the chart, ASM #3 stated, "No because I don't consider them part of the permanent record." ASM #3 stated he was always behind on dictations, especially for routine visits. ASM #3 was made aware Resident #11's printed notes were electronically signed by him on this same day (7/7/16). ASM #3 confirmed he had dictated the notes this same day. ASM #3 stated he had been pulling together his handwritten notes and dictating typed notes this day because the dictated notes were supposed to be on the	F 514	F514 Continued from Page 117 8. Resident # 10 - Handwritten and dictated notes for physician visits on 03/26/16, 05/26/16 and 07/27/16 were signed and dated by the Medical Director and placed on the medical record on 07/27/16. 9. Resident # 9 - Handwritten and dictated notes for physician visits on 11/09/15, 12/07/15, 02/02/16, 04/07/16, 05/05/16, and 05/15/16 were signed and dated by the Medical Director and placed on the medical record on 07/26/16. **Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice?** All in-house residents have the potential to be affected by this practice. A medical record audit was completed by the HIM director on 07/13/2016 to indicate last physician and/or nurse practitioner visit filed in the chart.	

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F 514	Continued From page 118 clinical record. ASM #3 stated he has an assistant who is supposed to help enter information into the computer but the computer system would not allow his assistant to do so because of HIPAA (health insurance portability and accountability act) (1) regulations. On 7/7/16 at 5:25 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility policy titled, "Physician Services Guidelines" documented, "Policy: Documentation in the medical record must reflect supervision of medical care of each resident in the facility. All opinions that require physician judgement are signed and dated only by the physician or his designated representative (i.e., physician's assistant, clinical nurse specialist, or nurse practitioner) per state guidelines...At the time of each visit, the physician must review the resident's total program of care, medications, treatments, and the care plan. A progress note must be written, signed, and dated at the time of each visit and include the following. Significant change in condition... Change in diagnosis Change in medications... Progress and problems in meeting care plan goals Measures taken to reach highest practical mental/physical functional level... Status of specialized treatments and medical indications... Documentation regarding advanced directives... " No further information was presented prior to exit. (1) Health Insurance Portability and Accountability	F 514	F514 Continued from Page 118 Interim Executive Director (IED) and the Physician/Medical Director (MD) were notified of the results of the audit on 07/13/2016 by the HIM director. The Interim Executive Director (IED) met with the Medical Director (MD) and Director of Nursing (DON) on 07/18/2016 and a plan was put in place to correct all concerns identified by the HIM audit. All concerns will be addressed by 07/29/2016. **Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.** The Medical Director, Nurse Practitioner and other Attending Physician were educated by the Interim Executive Director on 07/12/16 regarding policy and procedure for documenting physician visits. To properly document a physician visit in the chart there must be a written	

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F 514	Continued From page 119 Act (HIPAA) - "Most of us believe that our medical and other health information is private and should be protected, and we want to know who has this information. The Privacy Rule, a Federal law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information. The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written, or oral. The Security Rule is a Federal law that requires security for health information in electronic form." This information was obtained from the website: http://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html 2.a. Resident #3 was admitted to the facility on 2/19/15 and readmitted on 3/29/16 with diagnoses including, but not limited to: history of a stroke with one-sided paralysis, depression, enlarged prostate with obstruction, and chronic kidney disease. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 5/4/16, he was coded as being moderately cognitively impaired for	F 514	F514 Continued from Page 119 progress note placed on the medical record at time of visit. This can be written as progress note or a Physician Visit/Recertification Form or a brief notation regarding the visit including date and signature with notation that dictation will follow. A Physician's Visit/Recertification form was put in place for all visits when a dictated note will not be completed within 72 hours. The physician completing the visit will complete the form, including signature and date. The handwritten documentation will be given to HIM or HIM assistant to update the documentation audit and then placed on the medical record until dictation is available. Health Information Manager (HIM) or HIM assistant will audit required physician visits and keep a running log of physician documentation needed. A list of all visits documented directly in the medical record or completed hand written or dictated notes be given to HIM department for verification of completeness and filed on the medical record.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495139	A. BUILDING _____ B. WING _____	07/08/2016

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

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F 514	Continued From page 120 making decisions. He was coded as having a suprapubic catheter in place. On the following dates and times, Resident #3 was observed in his room, and to have a suprapubic catheter draining in to a collection bag, encased in a privacy cover: 7/6/16 at 12:35 p.m. and at 3:10 p.m.; 7/7/16 at 8:10 a.m. and 2:40 p.m. During all observations, the urine in the collection bag was clear yellow. A review of the physician's orders for Resident #3 revealed the following order, written 3/29/16: "SP (suprapubic) cath (catheter) to bed side drainage for BPH (benign prostatic hyperplasia - enlarged prostate) with obs (obstructive) uropathy TID (three times a day)." A review of the nurses notes for Resident #3 revealed, in part, the following: - 6/20/16 at 5:53 p.m.: "Noted resident Foley bag and tubing with clear yellow urine." - 6/23/16 at 3:37 a.m.: "...Supra pubic catheter intact draining bloody urine..." - 6/23/16 at 10:36 p.m.: "Resident Supra Pubic catheter is intact and patent with bloody urine in bag..." - 6/24/16 at 10:02 a.m.: "Resident's catheter is noted to be leaking. Red tinged urine is noted..." - 6/27/16 at 7:52 a.m.: "Catheter continues to leak. 250 ml (milliliters) of bloody urine in catheter bag. Reported to oncoming shift." - 6/30/16 at 3:26 a.m.: "Resident cont (continued) with suprapubic catheter and noted to continue with bloody urine leaking around insertion site..." - 6/30/16 at 10:27 p.m.: "Resident returned from ER (emergency room) at 8:30 p.m. Report from	F 514	F514 Continued from Page 120 Beginning on 07/25/16, the IED, SDC and/or DON will provide education to all licensed nurses regarding proper documentation related to a resident's change in condition, including assessments needed and documentation required when sending a resident out of the facility for unplanned evaluation and treatment. Education also includes notifying the Nurse Practitioner or Attending Physician and the responsible party regarding the change and proper documentation in the medical record of this notification. This education will be completed by 08/05/16. **Criterion # 4 – How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?** Results of audits regarding Complete Documentation of change in condition in the medical record as well as Physician Visits being documented on medical record will be reported for	

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F 514	Continued From page 121 [name of nurse] at [name of local hospital] was that sp cath was replaced and x-ray to confirm placement. Urine is bloody in collection bag..." Further review of the nurses notes revealed no evidence of further documentation regarding Resident #30's transfer to the emergency room on 6/30/16. A review of the comprehensive care plan for Resident #3 dated 3/29/16 revealed, in part, the following: "Report any changes in bladder status to nurse. F/U (follow up) with urology as scheduled...Observe for and report any signs and symptoms of UTI (urinary tract infection) to physician." On 7/7/16 at 2:10 p.m., LPN (licensed practical nurse) #4 who regularly cares for Resident #3, was interviewed. When asked if she could find evidence that the physician had been notified of Resident #3's transfer to the emergency room on 6/30/16 or of the events surrounding the resident's transfer to the emergency room on 6/30/16, LPN #4 stated: "I don't know. There's nothing here to tell what happened. That nurse is on vacation this week. I would have written a note." On 7/7/16 at 2:45 p.m., LPN #2, a unit manager, was interviewed. When shown the above referenced nurses notes, she stated she could not find evidence of assessment/documentation regarding the transfer to the emergency room on 6/30/16. LPN #2 stated: "The doctor should have been made aware of all of that. There should have been a note." On 7/7/16 at 5:30 p.m., ASM (administrative staff	F 514	F514 Continued from Page 121 review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the Director of Nursing (DON), Health Information Manager (HIM), or Unit Manager (UM) for 3 months or until 100% compliance is achieved.	08/05/16

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F 514	Continued From page 122 member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy entitled "Changes in Resident's Condition or Status" revealed, in part, the following: "Nursing services will be responsible for notifying the resident's attending physician when:...There is significant change in the resident's physical, mental or emotional status...A decision has been made to transfer or discharge the resident from the facility...All changes in the resident's medical condition must be properly recorded in the resident's medical record in accordance with our documentation policies and procedures." No further information was provided prior to exit. (1) "A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem." This information is taken from the website https://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000145.htm. According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of	F 514		

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documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team."

b. The facility staff failed to include a record of physician visits for Resident #3 on the clinical record.

A review of the physician's progress notes for Resident #3 revealed no notes since the 3/29/16 readmission.

On 7/7/16 at 3:15 p.m., ASM (administrative staff member) #3, Resident #3's attending physician and the facility medical director was interview. He stated he was aware that getting his notes typed and placed in the medical record had been "a huge issue here." He stated that he makes the required visits, but is weeks, sometimes months, behind in getting the progress note typed and placed in the medical record. He stated: "Is it acceptable? No. But it's the best I can do." He stated he keeps hand-written notes from each visit, then later types the notes and gives them to the facility staff for placement in the clinical record.

On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns.

On 7/8/16 at 8:30 a.m., the surveyor was provided with evidence of ASM #3's hand-written notes for visits to Resident #3 on 3/30/16 and

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F 514	Continued From page 124 6/16/16. No further information was provided prior to exit. 3. The facility staff failed to include a record of physician visits for Resident #4 on the clinical record. Resident #4 was admitted to the facility on 2/9/16 with diagnoses including, but not limited to: chronic kidney disease, diabetes, congestive heart failure and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 5/18/16), she was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). A review of physician progress notes revealed no recertification notes since the resident was admitted on 2/9/16. On 7/7/16 at 3:15 p.m., ASM (administrative staff member) #3, Resident #4's attending physician and the facility medical director, was interviewed. He stated he was aware that getting his notes typed and placed in the medical record had been "a huge issue here." He stated that he makes the required visits, but is weeks, sometimes months, behind in getting the progress note typed and placed in the medical record. He stated: "Is it acceptable? No. But it's the best I can do." He stated he keeps hand-written notes from each visit, then later types the notes and gives them to the facility staff for placement in the clinical record.	F 514		

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F 514	Continued From page 125 On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. On 7/8/16 at 8:30 a.m., the surveyor was provided with evidence of ASM #3's hand-written notes for visits to Resident #4 on 3/9/16, 4/5/16, 5/27/16 and 7/1/16. No further information was provided prior to exit. 4. The facility staff failed to include a record of physician visits for Resident #8 on the clinical record. Resident #8 was admitted to the facility on 6/27/13 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, chronic back pain and anxiety disorder. On the most recent MDS (minimum data set), an annual assessment dated 6/10/16, Resident #8 was coded as being cognitively intact for making daily decisions. A review of the clinical record failed to reveal evidence of physician recertification visits since 7/13/15. On 7/7/16 at 3:15 p.m., ASM (administrative staff member) #3, Resident #8's attending physician and the facility medical director, was interviewed. He stated he was aware that getting his notes typed and placed in the medical record had been "a huge issue here." He stated that he makes the required visits, but is weeks, sometimes months, behind in getting the progress note typed and	F 514		

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F 514	Continued From page 126 placed in the medical record. He stated: "Is it acceptable? No. But it's the best I can do." He stated he keeps hand-written notes from each visit, then later types the notes and gives them to the facility staff for placement in the clinical record. On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. On 7/8/16 at 8:30 a.m., the surveyor was provided with evidence of ASM #3's hand-written notes for visits to Resident #8 on 11/13/15, 1/8/16, 2/23/16 and 6/18/16. No further information was provided prior to exit. 5. Resident # 2 did not have copies of the physician progress notes for 2/9/16, 2/29/16, 3/5/16 4/1/16, 4/29/16, and 5/27/16 on the clinical record. Resident # 2 was admitted to the facility on 1/4/16 and most recently readmitted on 3/4/16 with diagnoses that included but were not limited to: hypertension, hyperlipidemia, dementia, hypothyroidism, atrial fibrillation, and depression. Resident # 2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/27/16, coded Resident # 2 as understood by others and able to understand others. Resident # 2 was coded as scoring 11 of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive	F 514		

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F 514	Continued From page 127 Patterns, indicating the resident was moderately cognitively impaired. Review of the clinical record revealed no physician progress notes by the attending physician. During an interview on 7/7/16 at 11:50 a.m. with OSM (other staff member) # 2, OSM # 2 revealed that every week she (OSM # 2) makes a list of all residents that need to be seen by the physician. OSM # 2 stated that she gives the list to the physician each week; OSM # 2 stated that the physician does handwritten notes, then takes the notes and types them up. OSM # 2 further stated that the typed notes don't always get on the chart. During an interview on 7/7/16 at 3:17 p.m. with ASM (administrative staff member) # 3, the physician, revealed that records are a problem stating, "I've been asking for help for some time to do all the paperwork. I'm getting help next week. I'm always behind in dictation. My hand written notes are not acceptable - what use is a note that you can't read. I recognize that it is a problem. I have handwritten notes for each resident but do not consider my notes a part of the record so I do not date and sign them." ASM # 3 was asked if we could see his notes. ASM # 3 responded that we could. On 7/8/16 at 8:25 a.m. a list of the dates for each visit for each resident was provided by ASM # 1, the executive director. This list documented that ASM # 3 visited Resident # 2 on 2/9/16, 2/29/16, 3/5/16 4/1/16, 4/29/16, and 5/27/16. The notes corresponding to these dates were also provided and as ASM # 3 stated they were not signed or dated and not part of the clinical record.	F 514		

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F 514	Continued From page 128 During an interview on 7/8/16 at 8:32 a.m. with ASM # 2, ASM # 2 stated, "I presented everything I have." 6. Resident # 12 did not have copies of the physician progress notes for 12/4/15, 1/29/16, 3/25/16, and 5/20/16 on the clinical record. Resident # 12 was admitted to the facility on 6/20/14 and most recently readmitted on 7/17/15 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease, congestive heart failure, hypertension, hyperlipidemia, hypothyroidism, atrial fibrillation, congestive heart failure, and bi-polar disorder*. Resident # 12's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/15/16, coded Resident # 12 as understood by others and able to understand others. Resident # 12 was coded as scoring 15 of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was cognitively intact. *Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels. www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml Review of the clinical record revealed no physician progress notes by the attending physician.	F 514		

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F 514	Continued From page 129 During an interview on 7/7/16 at 11:50 a.m. with OSM (other staff member) # 2, OSM # 2 revealed that every week she (OSM # 2) makes a list of all residents that need to be seen by the physician. OSM # 2 stated that she gives the list to the physician each week; OSM # 2 stated that the physician does handwritten notes, then takes the notes and types them up. OSM # 2 further stated that the typed notes don't always get on the chart. During an interview on 7/7/16 at 3:17 p.m. with ASM (administrative staff member) # 3, the physician, revealed that records are a problem stating, "I've been asking for help for some time to do all the paperwork. I'm getting help next week. I'm always behind in dictation. My hand written notes are not acceptable - what use is a note that you can't read. I recognize that it is a problem. I have handwritten notes for each resident but do not consider my notes a part of the record so I do not date and sign them." ASM # 3 was asked if we could see his notes. ASM # 3 responded that we could. During the end of day interview on 7/7/16 at 5:30 p.m. with ASM (administrative staff member) # 1, executive director, and ASM # 2, director of nurses, were made aware of the missing physician progress issue. At this time a request was made for the facility policy. On 7/8/16 at 8:25 a.m. a list of the dates for each visit for each resident was provided by ASM # 1, the executive director. A list of the dates for each visit for each resident was provided. This list documented that ASM # 3 visited Resident # 12 on 12/4/15, 1/29/16, 3/25/16, and 5/20/16. Only one note corresponding to these dates was provided (3/25/16) and as ASM # 3 stated it was	F 514		

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not signed or dated and was not part of the clinical record.

During an interview on 7/8/16 at 8:32 a.m. with ASM # 2, ASM # 2 stated, "I presented everything I have."

No further information was provided prior to exit.

7. Resident # 13 did not have copies of the physician progress notes for 12/4/15, 3/25/16, and 5/20/16 on the clinical record.

Resident # 13 was admitted to the facility on 6/20/06 and most recently readmitted on 1/30/15 with diagnoses that included but were not limited to: congestive heart failure, hyperlipidemia, diabetes, multiple sclerosis*, and gastroesophageal reflux disorder. Resident # 13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/1/16, coded Resident # 13 as understood by others and able to understand others. Resident # 13 was coded as scoring 11 of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was moderately cognitively impaired.

*Multiple sclerosis (MS) is a disease of the central nervous system. In MS the body's immune system attacks myelin, which coats nerve cells. nccih.nih.gov/health/multiple-sclerosis

Review of the clinical record revealed no physician progress notes by the attending physician.

During an interview on 7/7/16 at 11:50 a.m. with

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F 514	Continued From page 131 OSM (other staff member) # 2, OSM # 2 revealed that every week she (OSM # 2) makes a list of all residents that need to be seen by the physician. OSM # 2 stated that she gives the list to the physician each week; OSM # 2 stated that the physician does handwritten notes, then takes the notes and types them up. OSM # 2 further stated that the typed notes don't always get on the chart. During an interview on 7/7/16 at 3:17 p.m. with ASM (administrative staff member) # 3, the physician, revealed that records are a problem stating, "I've been asking for help for some time to do all the paperwork. I'm getting help next week. I'm always behind in dictation. My hand written notes are not acceptable - what use is a note that you can't read. I recognize that it is a problem. I have handwritten notes for each resident but do not consider my notes a part of the record so I do not date and sign them." ASM # 3 was asked if we could see his notes. ASM # 3 responded that we could. During the end of day interview on 7/7/16 at 5:30 p.m. with ASM (administrative staff member) # 1, executive director, and ASM # 2, director of nurses, were made aware of the missing physician progress issue. At this time a request was made for the facility policy. On 7/8/16 at 8:25 a.m. a list of the dates for each visit for each resident was provided by ASM # 1, the executive director. A list of the dates for each visit for each resident was provided. This list documented that ASM # 3 visited Resident # 13 on 12/4/15, 3/25/16, and 5/20/16. No notes corresponding to these dates were provided. During an interview on 7/8/16 at 8:32 a.m. with	F 514		

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F 514	Continued From page 132 ASM # 2, ASM # 2 stated, "I presented everything I have." No further information was provided prior to exit. 8. The facility staff failed to include a record of physician visits for Resident #10 on the clinical record. Resident #10 was admitted to the facility on 1/8/16 with diagnoses that included but were not limited to: arthritis, dementia, high blood pressure, kidney disease and diabetes. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 4/13/16 coded the resident as having a six out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. Review of the clinical record did not evidence documentation of a physician re-certification for services note from 7/9/15 to 7/7/16. A request was made to ASM (administrative staff member) #2, the director of nursing, on 7/7/16 for all of the physician progress notes for Resident #10. An interview was conducted on 7/7/16 at 11:00 a.m. with OSM (other staff member) #2, the medical records staff. When asked if the physician's progress notes were to be in the chart, OSM #2 stated that they should. When asked the process she followed to track the physician's visits, OSM #2 stated, "I make a list every week and give it to the doctor." OSM #2	F 514		

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	495139	A. BUILDING _____ B. WING _____	07/08/2016

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stated that the physician had handwritten notes but had not put them into the computer so the notes were not available in the resident's clinical record.

An interview was conducted on 7/7/16 at 3:18 p.m. with ASM #3, the physician. When asked about his notes, ASM #3 stated, "When asking for records it's a huge issue here. I have been asking my bosses to give me a solid week off and then some help to keep up with it. Some doctors write notes you can't read. I scribble notes as I go along and then dictate my notes, I'm always behind in my dictation. I keep a list of when I see recerts." ASM #3 showed the form that he completes when he examines the residents. When asked if he signed and dated his handwritten notes, ASM #3 stated, "No, because I don't think it's part of the permanent record." When asked if it was acceptable that there were no physician notes on the chart, ASM #3 stated, "No."

On 7/7/16 at 5:15 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

On 7/8/16 at 8:30 a.m. ASM #2 brought the physician's handwritten note dated 3/25 (no year documented). When asked if there were any other notes, ASM #2 stated, "If there is something you didn't get, we don't have it."

Review of the facility's policy titled, "Physician Services Guidelines" documented, "Policy. Documentation in the medical record must reflect supervision of the medical care of each resident in the facility. All opinions that require physician judgement are signed and dated....Procedure. A

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progress note must be written, signed and dated at the time of each visit...A dictated progress note is acceptable, provided the physician writes, signs and dates a progress note that indicates that a note was dictated and will be transcribed."

No further information was provided prior to exit.

9. There were no physician progress notes in the clinical record for Resident #9 since12/7/15.

Resident #9 was admitted to the facility on 3/3/12 with diagnoses that included but were not limited to: pneumonia, high blood pressure, low back pain, dementia, pain, hypothyroid disease, and dysphagia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/14/16, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. Resident #9 was coded as requiring limited assistance of one staff member for eating.

Review of the clinical record revealed the last documented physician visit to be 12/7/15. There were multiple notes by the nurse practitioner but none by the physician for Resident #9.

An interview was conducted with other staff member (OSM) #2, the medical records employee, on 7/7/16 at 10:59 a.m. When asked

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who tracks physician visits, OSM #2 stated, "I do." She further expanded stating, "He (physician) has handwritten sheets. He has them in a pile in his office until he puts them in the computer. He has asked for help and it's coming next week. I have asked and asked for him to do things but I can't make him do something. I've even contacted my corporate person. He takes notes and then doesn't put it in the computer. He's employed by a physician service within our corporation." A request was made to speak with the physician.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 7/7/16 at 11:17 a.m. When asked if the physician's progress notes should be in the clinical record, ASM #2 stated, "Yes."

An interview was conducted with ASM #3, the physician for Resident #9, on 7/7/16 at 3:20 p.m. ASM #3 stated, "It's a huge issue here. I work for an (name of corporation) affiliate. I wanted a solid week to catch up. They have finally gotten me coverage next week so I can dictate my notes. When someone comes in, I write a handwritten H & P (history and physical) but it's unreadable. I hand scribble notes and then dictate afterwards. I am always behind in dictations. Especially for ones who don't get seen with too many care concerns. I have an assistant who was to help me put them in the computer but they won't allow her to put them in the computer." When asked how he knows who to see, ASM #3 stated, "I have a list of people I see." ASM #3 further stated, "Is this acceptable, no but my notes would be shorter. I want my notes to be readable and have all of the information on them. The routine stuff, I keep a list of recerts

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F 514	Continued From page 136 (recertification's). The recerts usually are done on Tuesday, Wednesday and Thursday. I run around and scribble a note." When asked if he was aware of the regulations regarding the physician visits and progress notes, ASM #3 stated, "Yes, I am." ASM #3 further stated, "When I do a recert, I look at the medications, lab results, dose reductions. The nurse practitioner cannot do the recerts. When I do the recerts, that's the time I review the nurse practitioner's work." When asked what would happen if something happened to him, ASM #3 stated, "It would be a mess but I feel there is enough information that could be used to follow the care. But that's my problem; I want the notes to be more readable and accurate. It's not good. I'm putting together my handwritten notes into the computer for the ones you have requested." On 7/7/16 at 4:46 p.m. ASM #3 brought a list of resident names and handwritten notes of when they were seen. ASM #3 stated, "I do not have any list prior to December." The list documented Resident #7 was seen on 1/30/16, 4/7/16 and 5/5/16. ASM #3 was requested to provide the handwritten notes of these visits. The executive director and ASM #2, the director of nursing, were made aware of the above findings on 7/7/16 at 5:28 p.m. A request was made to provide evidence of the physician visits for Resident #9 since 12/7/15. On 7/8/16 at 8:27 a.m. three handwritten progress notes were received for 2/2/16, 4/7/16 and 5/5/16. No further information was provided prior to exit.	F 514		