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	495412	A. BUILDING _____ B. WING _____	C 04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVA HEALTH AND REHAB	377 CLONCE ST WEBER CITY, VA 24290

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 04/12/16 through 04/14/16. Two complaints were invesigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 90 certified bed facility was 84 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents 1 through 14) and 3 closed record reviews (Residents 15 through 17).

F 205 SS=D 483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR

F 205

Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

RECEIVED
APR 29 2016
VDH/OLC

1. Resident #16 is no longer in the facility.
2. All residents have the potential to be affected by this issue.
3. The Administrator and Social Worker have been reeducated concerning the facility policy concerning the discharge of a resident.
4. The Administrator will report all facility decided discharges to the QAPI committee for review and recommendations.
5. The Allegation of Compliance date for this plan is May 6, 2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Johnna Eddy, LNHA | TITLE: Administrator | (X6) DATE: 4/28/2016

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

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to readmit 1 of 17 Residents (Resident #16) after a hospitalization.

The findings included.

The facility staff failed to readmit Resident #16 after a hospitalization. The Resident was private pay and had paid for the room in advance.

Resident #16's clinical record was reviewed on 04/13 and 04/14/16.

Resident #16 was admitted to the facility on 02/13/15. Diagnoses included, but were not limited to, atrial fibrillation, congestive heart failure, osteoporosis, anxiety, hypertension, dysphagia, and acute/chronic systolic and diastolic heart failure.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/22/15 included a documented BIMS (brief interview for mental status) score of 3 out of a possible 15 points indicating the Resident was severely impaired in cognitive skills for daily decision making.

The clinical record included a discharge MDS assessment with an ARD of 06/07/15 that had been coded "Discharge assessment-return anticipated."

Resident #16's clinical record indicated that the

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F 205	Continued From page 2	F 205		

Resident was transferred and admitted to a local hospital on 06/07/15.

When the Resident was ready for discharge from the hospital the facility refused to readmit the Resident. Resident #16's clinical record included a progress note dated 06/17/15 that had been transcribed by SW #1 (social worker). This progress note read in part " ...Dtrs (daughters) in office and spoke with SSD and SSA. Dtr. (daughter) _____ asked questions about res. (resident) bed hold and private pay that had been paid in advance for the month of June. _____ was explained that res. was discharged from the facility on the day that she was admitted to the hospital and they will be issued a refund from the corporate office for those days she was not in the facility. She stated they had agreed to pay a bed hold. She was again explained that she would be issued a refund from the date of discharge to the hospital. She then requested that this be put in writing..."

The business office was able to provide the surveyor a copy of a refund check made payable to the Resident. The reason transcribed on the "Resident Refund Request Form" was documented as "Private Pay overpay due to discharge." This form had been signed by the administrator and was dated 06/24/15. The discharge date was documented as 06/07/15.

The facility provided the surveyor with a copy of their admission agreement. Page 8 of this agreement addressed bed holds and read in part. "Bed Hold and Leave of Absence If a Resident's primary pay source is PRIVATE PAY, the FACILITY will automatically hold a Resident's bed at the routine per diem charge pending the

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F 205	Continued From page 3	F 205		

Resident's stay in a hospital or any other place outside the FACILITY, unless the FACILITY is specifically instructed in writing not to hold the bed prior to the Resident leaving the FACILITY, by the Resident or the Representative, regardless of whether the Resident actually returns to the Facility..."

The facility also provided the surveyor with a copy of their "Skilled Nursing Resident Handbook." Appendix B of this handbook addressed the facility transfer and discharge policy. "Transfers from the Facility may be made if, in the physician's judgment, the changes in the Resident's level of care warrant such a transfer. In addition, a transfer may be made for reasons affecting the Resident's welfare or the welfare of other Residents, as well as nonpayment of charges. The Resident will be provided advance notice of a transfer (except in emergency or if authorized by statute of Health Department rules), which allows you time to make your wishes known and to participate in the planning for such a move...Thirty (30) days advance written notice, including the reason for discharge, will be provided unless: 1) Endangerment to the health or safety or others in the facility; 2) When a resident's health has improved to allow a more immediate transfer or discharge; 3) When a resident's urgent medical needs require more immediate transfer; 4) When a resident has not resided in the facility for 30 days, or 5) the resident leaves against medical advice..."

SW #1 provided the surveyor with a signed copy of "AUTHORIZATION & ACKNOWLEDGEMENT OF RECEIPT" that listed several documents that the AR (authorized representative) had signed as receiving and included #7 "Information on the

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Facility Bed hold and Leaves of absence procedures and responsibilities." The facility representative that signed this form had dated it 02/23/15. There was no date beside the AR's signature.

On 04/13/16 at approximately 4:15 p.m. an end of the day meeting was held with the administrator and DON (director of nursing). When asked about the Resident being discharged from the facility the administrator verbalized to the survey team that they couldn't meet the needs of the daughter so they did not take the Resident back. The DON verbalized to the surveyor that she had received a call from the facility staff on at least one occasion stating the daughters were in the Residents room and they were being very loud and bothering other Residents of the facility.

On 04/14/16 at approximately 1:30 p.m. the surveyor interviewed SW #1, surveyor #2 was in attendance during this interview, SW #1 verbalized to the surveyors that the Resident's family were often loud and they had received complaints from other Residents and family members concerning the Resident's family being loud and asking other Resident's questions. SW #1 stated they had offered the family of the Resident a private room for Resident #16 three times but they had declined.

SW#1 verbalized to the surveyor that they (the facility) had collectively decided they could not meet the Residents needs-Couldn't keep the family satisfied. When asked if they had provided the family or the Resident with a 30 day discharge notice she stated they had not. SW #1 stated that prior to the Resident being sent to the hospital that they had been advised by corporate

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F 205	Continued From page 5 that they may need to give a 30 day discharge notice. On 04/14/16 at approximately 2:15 p.m. during an interview with the administrator. The administrator verbalized to the survey team that when the Resident was sent out to the hospital they were already debating a discharge notice as some of the other Residents and staff were complaining about how loud the family was and their demeanor toward other Residents of the facility. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 205		
F 242 SS=D	THIS IS A COMPLAINT DEFICIENCY. 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview and clinical record review the facility staff failed to honor Resident food choices for 1 of 17 Residents, Resident #1. The finding included:	F 242	1. Resident #1 has been interviewed and preferences have been updated. 2. All residents have the potential to be affected. Preferences have been updated for all residents capable of stating their wishes.	

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For Resident #1 the facility staff failed to honor food choices.

Resident #1 was admitted to the facility on 11/10/15 and readmitted on 03/15/16. Diagnoses included but not limited to anemia, hypertension, urinary tract infection, hyperlipidemia, anxiety, depression, gastroesophageal reflux disorder, obesity, and cancer.
The most recent comprehensive MDS with and ARD (assessment reference date) of 12/30/15 coded the Resident as 12 of 15 in Section C, cognitive patterns. This is a significant change MDS.

Resident #1 was interviewed by the surveyor on 04/12/16 at approximately 1430. Resident #1 was alert and oriented at the time of the interview. When surveyor asked Resident #1 about the food she was served, Resident #1 stated "Most of the time it's not hot enough, they gave me biscuits and gravy and it was cold. Who wants cold biscuits and gravy? I told them that I don't want that anymore and that's what I had for breakfast this morning." The surveyor asked if the food was cold this morning and the Resident stated "I don't know, because I didn't eat it."

The surveyor spoke with Resident #1 again on 04/13/16 at approximately 0745. Surveyor asked Resident how she was doing this morning and she stated " Good, I'm having scrambled eggs this morning". At approximately 0800, surveyor again spoke with Resident #1 after observing meal tray being delivered to room. When surveyor entered Resident's room, Resident stated "Look what I ended up with?", and pointed to food tray. Resident's meal tray was observed on overbed table. Tray consisted of biscuits and

3. The dietary staff have been reeducated to follow the stated preferences on the tray card for each resident and to report any new preference stated by the resident to the dietary manager. The dietary manager will then update the tray card. The dietary manager will continue to update preferences quarterly. Nursing staff have been reeducated to report all newly stated food preferences made by a resident to the dietary staff or the Dietary Manager.

4. The Dietary Manager will audit 25% of resident trays one meal a day, 5 days a week for 4 weeks. The results of this audit will be reported to the monthly QAPI meeting for review and recommendations.

5. The allegation of compliance date for this plan is May 6, 2016

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F 242	Continued From page 7 gravy, fried egg, sausage patty, grits, cottage cheese and fruit. Resident's meal ticket was on tray and read in part "Grits, cornflakes, fried eggs, bacon, biscuit and gravy". Resident's dislikes were noted as "coffee, sausage, pancakes and oatmeal". Surveyor asked Resident if the food was warm enough, and Resident stated "I don't know because I'm not eating it". Resident then placed her finger in food and stated "Well, it's lukewarm". During a meeting with the administrator and DON (director of nursing) on 04/13/16 at approximately 1615 the concern of the Resident's diet choices not being honored was brought to their attention. The DON stated that the dietary manager and/or other dietary staff had spoken with the Resident on two separate occasions and made note of her likes/dislikes. Surveyor spoke with Resident #1 again on 04/14/16 at approximately 0900. Resident stated that she had received scrambled eggs, toast and jelly for breakfast and she was pleased. Surveyor noted that diet ticket reflected this. Diet ticket also now listed dislikes as bacon, sausage, biscuits and gravy. No further information was provided prior to exit.	F 242		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive	F 272	1. The CAAs going forward for Residents #3, #4, #5, #6, #8, #9, #1, #2, #7, and #10 will be completed with the location and date of supporting documentation. 2. All residents have the potential to be affected.	

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assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure accurate comprehensive MDS (minimum data set) assessments for 10 of 17 Residents, Residents #3, #4, #5, #6, #8, #9, #1, #2, #7 and #10.

3. The MDS Coordinator and MDS nurse will be in-serviced by the Regional Reimbursement Nurse on how to complete accurate CAAs on an MDS.
All future CAAs will include the location and date of supporting documentation.

4. Review of CAAs will be done for all comprehensive MDS completed by the Director of Nursing or designee weekly x 4 to ensure the CAA Summary Sheet reflects the date and location of supporting documentation.
The Director of Nursing will report results of the review at the monthly QAPI committee meeting for review and recommendations for the duration of the review documentation period.

5. The allegation of compliance date for this plan is May 6, 2016

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The findings included.

1. For Resident #3, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/04/16.

Resident #3 was admitted to the facility 01/09/15. Diagnoses included, but were not limited to, macular degeneration, osteoarthritis, hearing loss, dysphagia, and anemia.

Section C (cognitive patterns) of the Resident significant change in status MDS assessment with an ARD of 04/04/16 was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented "CAA WS (worksheet)" and had documented the dates of 4/5/2016, 4/10/2016, and 4/11/2016. The actual location(s) regarding the documentation had not been documented.

On 04/14/16 MDS nurse #1 was asked about the missing documentation and verbalized to surveyor #1 that this was the way she had been taught.

This information was shared with the DON

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(director of nursing) and administrator on 04/14/16 at approximately 3:10 p.m. No additional information was provided to the survey team prior to the exit conference.

2. For Resident #4, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/03/16.

Resident #4 was admitted to the facility 12/02/14. Diagnoses included, but were not limited to, chronic kidney disease, anemia, diabetes, and hypertension.

Section C (cognitive patterns) of the Resident annual MDS assessment with an ARD of 03/03/16 included a documented summary score of 15 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented "CAA WS (worksheet)" and had documented the date of 3/4/2016. The actual location(s) regarding the documentation had not been documented.

On 04/14/16 MDS nurse #1 was asked about the missing documentation and verbalized to surveyor #1 that this was the way she had been taught.

This information was shared with the DON

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(director of nursing) and administrator on 04/14/16 at approximately 3:10 p.m. No additional information was provided to the survey team prior to the exit conference.

3. For Resident #5, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/09/15.

Resident #5 was admitted to the facility 08/07/15. Diagnoses included, but were not limited to, macular degeneration, osteoarthritis, hearing loss, dysphagia, and anemia.

Section C (cognitive patterns) of the Resident significant change in status MDS assessment with an ARD of 11/09/15 included a documented summary score of 3 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented "CAA WS (worksheet)" and had documented the dates of 11/10/2015, 11/11/2015, and 11/16/2015. The actual location(s) regarding the documentation had not been documented.

On 04/14/16 MDS nurse #1 was asked about the missing documentation and verbalized to surveyor #1 that this was the way she had been taught.

This information was shared with the DON

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(director of nursing) and administrator on 04/14/16 at approximately 3:10 p.m. No additional information was provided to the survey team prior to the exit conference.

4. For Resident #6, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/16/16.

Resident #6 was admitted to the facility 07/10/15. Diagnoses included, but were not limited to, aphasia, dysphagia, diabetes, and hypertension.

Section C (cognitive patterns) of the Resident significant change in status MDS assessment with an ARD of 03/16/16 was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented "CAA WS (worksheet)" and had documented the dates of 03/16/2016, 03/17/2016, and 03/18/2016. The actual location(s) regarding the documentation had not been documented.

On 04/14/16 MDS nurse #1 was asked about the missing documentation and verbalized to surveyor #1 that this was the way she had been taught.

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This information was shared with the DON (director of nursing) and administrator on 04/14/16 at approximately 3:10 p.m. No additional information was provided to the survey team prior to the exit conference.

5. For Resident #8, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/29/15.

Resident #8 was admitted to the facility 09/26/14. Diagnoses included, but were not limited to, history of falls, shortness of breath, hypertension, anxiety disorder, and hypothyroidism.

Section C (cognitive patterns) of the Resident significant change in status MDS assessment with an ARD of 09/29/15 included a documented summary score of 3 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented "CAA WS (worksheet)" and had documented the date of 10/02/2015. The actual location(s) regarding the documentation had not been documented.

On 04/14/16 MDS nurse #1 was asked about the missing documentation and verbalized to surveyor #1 that this was the way she had been taught.

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This information was shared with the DON (director of nursing) and administrator on 04/14/16 at approximately 3:10 p.m. No additional information was provided to the survey team prior to the exit conference.

6. For Resident #9, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/29/16.

Resident #9 was admitted to the facility 12/12/13. Diagnoses included, but were not limited to, diabetes, chronic pain, heart failure, and hypertension.

Section C (cognitive patterns) of the Resident significant change in status MDS assessment with an ARD of 01/29/16 included a documented summary score of 15 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented "CAA WS (worksheet)" and had documented the dates of 01/28/2016, 02/01/2016, and 02/02/2016. The actual location(s) regarding the documentation had not been documented.

On 04/14/16 MDS nurse #1 was asked about the missing documentation and verbalized to surveyor #1 that this was the way she had been

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taught.

This information was shared with the DON (director of nursing) and administrator on 04/14/16 at approximately 3:10 p.m. No additional information was provided to the survey team prior to the exit conference.

7. For Resident #1 the facility staff failed to ensure an accurate comprehensive MDS (minimum data set) assessment.

Resident #1 was admitted to the facility on 11/10/15 and readmitted on 03/15/16. Diagnoses included but not limited to anemia, hypertension, urinary tract infection, hyperlipidemia, anxiety, depression, gastroesophageal reflux disorder, obesity, and cancer.

The most recent comprehensive MDS with and ARD (assessment reference date) of 12/30/15 coded the Resident as 12 of 15 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed.

The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was " see CAA WS (worksheet) 12/31/15 " .

The MDS coordinator was interviewed on 04/14/16 at approximately 0930. She stated that is how they were taught during MDS training.

The administrator, director of nursing, MDS coordinator, and staff development were informed of the findings during a meeting with the survey team on 04/14/16 at 1510.

No further information was provided prior to exit.

8. For Resident #2 the facility staff failed to ensure an accurate comprehensive MDS assessment.

Resident #2 was admitted to the facility on

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11/25/14 and readmitted on 01/04/16. Diagnoses included but not limited to hypertension, fracture, dementia, anxiety, depression, atrial fibrillation, chronic kidney disease, gastroesophageal reflux disorder, arthritis, and osteoporosis.

The most recent comprehensive MDS with an ARD of 01/11/16 coded the Resident as 5 of 10 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was " see CAA WS 01/13/16 " .
The MDS coordinator was interviewed on 04/14/16 at approximately 0930. She stated that is how they were taught during MDS training.
The administrator, director of nursing, MDS coordinator, and staff development were informed of the findings during a meeting with the survey team on 04/14/16 at 1510.
No further information was provided prior to exit.

9. For Resident #7 the facility staff failed to ensure an accurate comprehensive MDS assessment.

Resident #7 was admitted to the facility on 06/28/14 and readmitted on 09/01/15. Diagnoses included but not limited to congestive heart failure, hypertension, diabetes mellitus, hyperlipidemia, Alzheimer's disease, anxiety, coronary artery disease, depression, psychotic disorder, atrial fibrillation, gastroesophageal reflux disorder, insomnia, dementia and seizure disorder.

The most recent MDS with an ARD of 09/08/15 coded the Resident as 3 out of 15 in Section C,

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cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was " see CAA WS 09/10/15 " .
The MDS coordinator was interviewed on 04/14/16 at approximately 0930. She stated that is how they were taught during MDS training.
The administrator, director of nursing, MDS coordinator, and staff development were informed of the findings during a meeting with the survey team on 04/14/16 at 1510.
No further information was provided prior to exit.

10. For Resident #10 the facility staff failed to ensure an accurate comprehensive MDS assessment.

Resident #10 was admitted to the facility on 05/15/15. Diagnoses included but not limited to cancer, atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disorder, end stage renal disease, hyperlipidemia, Alzheimer's disease, dementia, anxiety, depression, chronic obstructive pulmonary disease, and obsessive-compulsive disorder.

The most recent comprehensive MDS with an ARD of 03/02/16 coded the Resident as 3 out of 15 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was " see CAA WS 03/02/16 " .
The MDS coordinator was interviewed on 04/14/16 at approximately 0930. She stated that

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F 272	Continued From page 18 is how they were taught during MDS training. The administrator, director of nursing, MDS coordinator, and staff development were informed of the findings during a meeting with the survey team on 04/14/16 at 1510. No further information was provided prior to exit.	F 272		
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, clinical record review, and in the course of a complaint investigation, the facility staff failed to follow physician orders for 1 of 17 Residents, Resident #16. The findings included. The facility staff failed to administer the antibiotic levaquin as ordered. Resident #16 was admitted to the facility 02/13/15. Diagnoses included, but were not limited to, atrial fibrillation, congestive heart failure, osteoporosis, anxiety, hypertension, dysphagia, and acute/chronic systolic and diastolic heart failure.	F 309	1. Resident #16 is no longer in the facility. 2. Residents who are prescribed antibiotics have a potential to be affected. 3. Licensed staff has been reeducated to obtain antibiotics from the facility stat box if the medication has not been received from pharmacy. 4. The Director of Nursing or designee will review the new orders during the morning clinical meeting to identify new antibiotic orders. The MAR will be reviewed to ensure that there was no delay in receiving the first dose. This will be documented 5 days a week for 4 weeks and then weekly x 4 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee for review and recommendations. 5. The allegation of compliance date for this plan is May 6, 2016.	

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F 309	Continued From page 20 at 1:06 p.m. and was later admitted to the hospital. On 04/14/16 at approximately 1:07 p.m. the surveyor interviewed pharmacist #1 via phone. Pharmacist #1 verbalized to the surveyor that the medication had arrived at the facility on 05/06/15 and no call had been placed to the pharmacy requesting a stat run to deliver the medication. LPN #1 was no longer employed at the facility and was unable to be interviewed. During an interview with RN (registered nurse) #3 on 04/14/16 at approximately 12:30 p.m. RN #3 was asked the procedure for obtaining medication after hours. RN #3 verbalized to the surveyor that you would check the stat box for the medication, call the pharmacy if the medication was not available in the stat box and ask the pharmacy for a stat run. RN #3 stated you could also call the physician back and see if they wanted to prescribe something else if the medication was not available. The administrator and DON (director of nursing) were notified of the above in an end of the day meeting with the survey team on 04/14/16 at approximately 3:10 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. THIS IS A COMPLAINT DEFICIENCY.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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The Resident had been discharged from the facility.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/22/15 had a documented summary score of 3 out of a possible 15 points.

The clinical record included a copy of a physicians order dated 05/15/15 at 7:45 p.m. for the antibiotic "Levaquin 500 mg i (one) PO (by mouth) QD (every day) X 10 days."

When reviewing the Residents MAR's (medication administration records) for May 2015 the surveyor was unable to find where this order had been transcribed onto the MAR.

A review of the nursing progress notes for 05/05/15 indicated that LPN (licensed practical nurse) #1 had documented the following at 19:25 (7:25 p.m.) "Called Dr. ____ (name omitted) with residents cxray (chest X ray) report: Conclusion: Modest right lower lobe and slight left lower lobe infiltrates. There is modest right pleural effusion....Levaquin 500 mg 1 po X 10 days."

There was no documentation in the clinical record to indicate why this medication had not been administered on 05/05/15.

A review of the facility stat box list indicated that this medication was stocked in the stat box at the facility.

On 05/06/15 at 12:32 a.m. LPN #1 documented "Family request to send resident to _____ hospital..." Resident #16 was transported by EMS

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Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on Resident interview, staff interview and clinical record review the facility staff failed to address an adverse reaction to a medication for 1 of 17 Residents, Resident #1.

The findings included:

For Resident #1 the facility staff failed to address an adverse reaction to the medication "oxycodone".

1. The oxycodone for Resident #1 has been discontinued.

2. Residents with listed allergies have the potential to be affected.

3. The licensed nursing staff has been reeducated to call the physician if a resident states that they are allergic to a medication, even if the physician has taken the medication off of the resident's allergy list.

4. The Director of Nursing or designee will review the new orders during the clinical morning meeting to identify orders that take a medication off the allergy list of a resident. This will be documented 5 days a week for 4 weeks and then weekly for 4 weeks.
The Director of Nursing will report the findings of the review to the monthly QAPI meeting for the duration of the monitoring time frame.

5. The allegation of compliance date for this plan is May 6, 2016.

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Resident #1 was admitted to the facility on 11/10/15 and readmitted on 03/15/16. Diagnoses included but not limited to anemia, hypertension, urinary tract infection, hyperlipidemia, anxiety, depression, gastroesophageal reflux disorder, obesity, and cancer.
The most recent MDS (minimum data set) with an ARD (assessment reference date) of 03/30/16 coded the Resident as 12 of 15 in Section C, cognitive patterns. Section J, health conditions, rated Resident #1 as having occasional pain with the worst pain at 8 out of 10 on the pain scale. This is a quarterly MDS.

The Resident's CCP (comprehensive care plan) was reviewed and contained a care plan for "Potential for pain related to non-Hodgkin ' s lymphoma, hx (history) of diverticular abscesses, s/p (status post) surgical procedure colostomy, and muscle spasms". Interventions listed under this plan were listed as "Monitor pain every shift, administer pain medication as per MD orders and note effectiveness, and acknowledge presence of pain and discomfort. Listen to Resident's concerns".

Resident #1 was interviewed by the surveyor on 04/12/16 at approximately 1430. Resident #1 was alert and oriented at the time of the interview. Resident #1 stated to the surveyor "I told them I was allergic to oxycodone, but they keep trying to give it to me anyway. You know, it ' s the same stuff as Percocet and I told them I can't take it". When surveyor asked Resident to elaborate, Resident stated "It makes me hallucinate. Last time I took it I saw kittens climbing the curtains and mice chewing on wire. I'm terrified of mice". Surveyor asked Resident if she had told facility staff about this and Resident stated "I told them

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but they said it was either that or a Xanax. They ain't even the same medicine. I would be happy with a Tylenol".

Resident #1's clinical record was reviewed on 04/12/16. It contained a face sheet which listed Resident drug allergies as "ciprofloxacin, epinephrine, hydrocodone, oxycodone, Claritin-D, Demerol, pencillins, antihistamines, and sulfonamides. The clinical record contained a signed POS (physician's order summary) which listed the Resident's allergies as "ciprofloxacin, epinephrine, hydrocodone, Claritin-D, Demerol, penicillins, antihistamines, and sulfonamides". This list also contained oxycodone, but entry was struck through and "resoloved" hand written below.

The POS also contained an entry which read in part "Oxycodone HCl Tablet 15 mg Give 1 tablet by mouth every 4 hours as needed for pain". Resident #1's MAR (medication administration record) for March 2016 was reviewed and contained the following entries which read in part "Roxicodone tablet 15mg (oxycodone HCl) Give 15mg by mouth every 6 hours as needed for pain". This entry had been signed as being administered on 03/09, 03/10 and 03/11/16. This order was discontinued on 03/11/16. MAR also contained an entry for "Oxycodone HCl tablet 15mg Give 1 tablet every 4 hours as needed for pain" with a start date of 03/15/16. This entry had been signed as being administered on 03/16, 03/17, 03/23 and 03/24/16. The MAR for April 2016 contained the following entry which read in part "Oxycodone HCl tablet 15mg Give 1 tablet by mouth every 4 hours as needed for pain. This entry had not been signed as having been administered.

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The surveyor contacted the facility pharmacy on 04/12/16 at approximately 1600 and spoke with pharmacist #1 regarding Resident #1's drug allergies. Pharmacist #1 stated that oxycodone is listed as allergies with the pharmacy. The pharmacist stated when they received an order for a medication listed as an allergy for a Resident; they call the facility to clarify the order. If the facility staff confirms that it is alright to send the medication, then the prescription would be filled. When surveyor asked specifically about Resident #1, pharmacist stated he had verified it was alright to send the medication with two different facility staff. Surveyor then asked pharmacist if there was any difference between the medications "oxycodone", "Roxicodone" and "Percocet". Pharmacist stated the only difference was the Percocet contains acetaminophen (Tylenol), and that the three medications are essentially the same. Pharmacist stated "Oxycodone is just the generic and Roxicodone is a brand name, if you are allergic to one of them, you will be allergic to the other."

The surveyor spoke with pharmacist #2 on 04/13/6 at approximately 1130. Pharmacist #2 stated Resident #1 had allergies to hydrocodone and oxycodone listed. Also stated the pharmacy had called the faculty to verify the prescription and was told Resident came from hospital on Roxicodone and the physician was aware of listed allergy, but said send it anyway.

Resident #1's clinical record contained a nurse's note dated 11/10/2015 at 23:46 which read in part "Spoke with .... (physician's name omitted) and received new order as follows: OK to send percocet and augmentin. Aware of allergy.

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Pharmacy notified".

Surveyor interviewed RN (registered nurse) #1 on 04/13/16 at approximately 1530. RN #1 stated MD sent a note to pharmacy saying it was alright to give oxycodone since the Resident had come from the hospital in this medication. Surveyor asked RN #1 if Resident #1 had ever complained of complications while taking the medication and RN #1 stated that she had not.

Surveyor interviewed LPN (licensed practical nurse) #1 on 04/13/16 at approximately 0900 and again at approximately 1550. During first interview, LPN #1 was asked by surveyor how allergies flag on the MAR. LPN #1 stated allergies are listed at the top of the MAR and the Resident's face sheet. Surveyor asked LPN #1 what would be her response if a Resident flagged for an Allery to a medication that was prescribed. LPN #1 stated she would call the pharmacy or MD for a clarification before administering. Surveyor asked LPN #1 what she would do if a Resident told her they were allergic to a specific medication and LPN #1 stated "I would not give it". During second interview, surveyor asked LPN #1 if Resident #1 had ever told her she was allergic to oxycodone. LPN #1 stated Resident had refused pain medication at times because she didn't feel like she needed something that strong.

Surveyor interviewed LPN #2 on 04/13/16 at approximately 0820 and again at 1600. During first interview LPN #2 was asked by surveyor how allergies flag on the MAR. LPN #2 stated they flag in red. Surveyor asked LPN #2 what would be her response if a Resident flagged for an allergy to a medication that was prescribed. LPN #2 stated "If

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F 329	Continued From page 26 the medication comes from the pharmacy or pharmacy calls, then we call the physician for a clarification order. If physician OK's it, then we give it". During second interview, surveyor asked LPN #2 if she had ever administered oxycodone to Resident #1. LPN #2 stated Resident #1 refused to take the oxycodone because she told me it makes her hallucinate". Surveyor asked LPN #2 if she had reported this and LPN #2 stated "I told the FNP (family nurse PR actioner)". The concern of the medication allergy was brought to the attention of the administrator and DON (director of nursing) during a meeting on 04/13/16 at approximately 1615. The DON provided the surveyor with a copy of a nurse' note dated 04/13/16 at 17:45 on 04/14/16 which read in part "N/O (new order) to d/c (discontinue) oxycodone d/t (due to) non use, N/O to start tylenol 325mg 2 tabs po (by mouth) q4hrs (every) PRN (as needed)-pain. Resident aware. No further information provided prior to exit.	F 329		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by:	F 363	1. All menus are now being followed as approved by the Dietician. 2. All residents have the potential to be affected.	

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F 363	Continued From page 27 Based on observation, Resident interview, staff interview and facility document review the facility staff failed to follow planned menus The findings included: The facility staff failed to follow planned menus for the breakfast meal. Surveyor reviewed the facility menu list for 04/12/16, 04/13/16 and 04/14/16. The menu for the breakfast meal on 04/12/16 was listed as "Juice of choice, cereal of choice, sausage patty, french toast, margarine and syrup, milk, coffee or hot tea". The menu for the breakfast meal on 04/13/16 was listed as "Juice of choice, cereal of choice, egg, hash browns, toast, margarine and jelly, milk, coffee or hot tea". The menu for the breakfast meal on 04/14/16 was listed as "Juice of choice, cereal of choice, sausage patty, pancakes, margarine and syrup, milk, coffee or hot tea. Alternative choices were not listed for either day. Surveyor observed the daily menu posted outside of the Resident's dining room and it was consistent with the menu list provided to the surveyor by facility staff. On 04/12/16, surveyor spoke with Resident #1 at approximately 1430. Resident #1 was alert and oriented at the time of the interview. Resident told surveyor that she did not like biscuits and gravy, but that she had been served biscuits and gravy for breakfast that morning. Surveyor again spoke with Resident #1 on 04/13/16 at approximately 0800. Resident #1 again told surveyor that she had been served biscuits and gravy for breakfast, and repeated that she did not like them. Surveyor observed meal tray on Resident's overbed table. Tray consisted of biscuits and gravy, fried egg,	F 363	3. The Dietary Manager has been reeducated that the menus can only be changed if approved by the Dietician. 4. The Administrator will audit one meal a day, 5 days a week for 4 weeks to monitor adherence to the menu as approved by the Dietician. The results of this monitoring will be brought to the QAPI committee by the Administrator for review and recommendation. 5. The allegation of compliance date for this plan is May 6, 2016.	

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sausage patty, grits, cottage cheese and fruit. Resident's meal ticket was on tray and read in part "Grits, cornflakes, fried eggs, bacon, biscuit and gravy". The meal ticket was not consistent with menu provided to the surveyor.

Resident #1 was admitted to the facility on 11/10/15 and readmitted on 03/15/16. Diagnoses included but not limited to anemia, hypertension, urinary tract infection, hyperlipidemia, anxiety, depression, gastroesophageal reflux disorder, obesity, and cancer.
The most recent comprehensive MDS with and ARD (assessment reference date) of 12/30/15 coded the Resident as 12 of 15 in Section C, cognitive patterns. This is a significant change MDS.

Surveyor observed other Residents meal trays and noted that the majority of the trays consisted of biscuits and gravy, egg and either sausage or bacon. On 04/14/16, surveyor again observed Residents breakfast meal trays. The majority of the meal trays consisted of biscuits and gravy, eggs and either sausage or bacon. Surveyor observed meal ticket on random Resident's tray. Meal ticket read in part "Biscuit and gravy, bacon, oatmeal and toast. Tray was observed to have same with the addition of fried egg.

Surveyor interviewed the dietary manager on 04/14/16 at approximately 0845 regarding the facility menus. The dietary manager stated to the surveyor "We were out of hash browns because the food truck had not delivered until late yesterday evening (04/13/16). The pancakes were frozen and the Residents don't like them anyway. They are the little frozen ones. We don't have a griddle to make homemade pancakes.

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F 363	Continued From page 29 We usually make biscuits and gravy every day, because most of the Residents like them". The concern of the incorrect menu was brought to the attention of the administrator and DON (director of nursing) during a meeting on 04/14/16 at approximately 1510.	F 363		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	1. RN#1 was immediately reeducated concerning appropriate hand hygiene during medication pass and pour process. 2. All residents have the potential to be affected. 3. Licensed nurses have been reeducated concerning appropriate hand hygiene during medication pass and pour process. 4. The Director of Nursing or RN designee will perform 3 medication pass and pour observations a week for 4 weeks with random staff. The results of these observations will be reported to the QAPI committee for review and recommendations. 5. The allegation of compliance date for this plan is May 6, 2016.	

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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, the facility staff failed to follow infection control policy and procedures for hand washing during a medication pass and pour observation on 1 of 5 halls the 400 hall.

The findings included.

RN (registered nurse) #1 failed to perform hand hygiene during a medication pass and pour observation on 04/13/16.

On 04/13/16 beginning at approximately 7:50 a.m. the surveyor observed RN #1 prepare and administer unsampled Resident #2's 8:00 a.m. medication. RN #1 was not observed by the surveyor to perform any hand hygiene after preparing and administering the Residents medication.

After administering the medication RN #1 pushed the medication cart to Resident #12's room prepared and administered her 8:00 a.m. medication and exited the room. RN #1 did not perform any hand hygiene after administering the medication.

RN #1 then pushed the medication cart to

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unsampled Resident #1's room and prepared and administered the Residents am medications. After administering the medications RN #1 was observed by the surveyor to use an antibacterial gel on her hands.

On 04/13/16 at approximately 8:25 a.m. the surveyor interviewed RN #1 regarding hand hygiene. When asked if she had performed any hand hygiene between administering the Residents medications RN #1 verbalized to the survey that she had not.

The administrator and DON (director of nursing) were notified that RN #1 failed to perform any hand hygiene between Residents during a medication pass and pour observation on 04/13/15 at approximately 4:15 p.m.

On 04/14/16 at approximately 8:50 a.m. the surveyor interviewed RN #2. RN #2 (infection control nurse) was asked by the surveyor if RN #1 should have completed any hand hygiene between Residents during the medication pass and pour observation. RN #2 verbalized to the surveyor that RN #1 should have washed her hands.

The facility policy/procedure titled "Hand Washing" read in part "Hand washing is the most important component for preventing the spread of infection...Perform hand hygiene: a. Before and after having direct contact with residents...f. After contact with inanimate objects (including medical equipment in the immediate vicinity of the resident). g. Wash hands with either plain or antimicrobial soap and water or rub hands with an alcohol-based formulation before handling medication and preparing food..."

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F 441	Continued From page 32 No further information regarding the infection control issue was provided to the survey team prior to the exit conference.	F 441		