PHEASANT RIDGE
NURSING AND REHAB CENTER
a Consulate Health Care Center

September 26, 2016

Mr. Rodney Miller
Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive,
Suite 401
Richmond, Va. 23233-1485

Dear Mr. Miller,

Enclosed is our Plan of Correction for Pheasant Ridge. The Plan of Correction will serve as the Facility's allegation of substantial compliance. Should you have any questions, please do not hesitate to call me at 540-725-8210.

Sincerely,

Mason Layne
Administrator

4355 Pheasant Ridge Road S.W. | Roanoke, VA 24014
p. (540) 725-8210 *f.* (540) 725-5735 | www.**consulate**healthcare.com

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 08/24/2016

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PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/22/16 through 8/24/16. Six complaints were investigated during the survey. The facility was not in compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 101 certified bed facility was 93 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents #1 through #16 and #20) and 3 closed record reviews (Residents #17 through #19).	F 000	**Preparation and submission of the Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the Plan of Correction is prepared and submitted solely because of the requirements under state and federal laws.** **The facility kindly requests that the Plan of Correction serve and be accepted as the Facility's allegation of substantial compliance.**	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155	1. For Resident # 8 , the Responsible Party and the Physician were notified and an Advanced Directive document was completed to include the necessary areas checked indicating the residents individual capacity as well as signatures from the RP and the physician. For Resident # 5, the most current code status has been determined and the physician's order for the resident's code status has been clarified. 2. For current residents residing in the center, a review has been completed of Advanced Directive documents and physician's orders for code status by the DCS/Designee to ensure that necessary/required areas on the document are completed, necessary/required signatures are present on the document,	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mason Layne — Executive Director — 9-26-16

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ɔgram participation.

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This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview the facility staff failed to ensure a complete and accurate Virginia Department of Health DDNR (durable do not resuscitate) form for 2 of 20 Residents, Residents #8 and #5 and failed to accurately determine code status for 1 of 20 Residents, Resident #5.

The findings included:

1. For Resident #8 the facility staff failed to accurately complete the Virginia Department of Health DDNR form.

Resident #8 was admitted to the facility on 02/22/15 and readmitted on 03/14/16. Diagnoses included but not limited to atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, aphasia, cerebrovascular accident, dementia, respiratory failure, and dysphagia.

The most recent MDS (minimum data set) with and ARD (assessment reference date) of 08/02/16 coded the Resident as 0 of 15 in section C, cognitive patterns. This is an annual MDS.

Resident #8's clinical record was reviewed on 08/23/16. It contained a Virginia Department of Health DDNR form which read in part:
"I further certify (must check 1 or 2)
[] 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment. (Signature of patient is required)

current code status has been determined, and the physician's order accurately reflects the most current code status..

3. Education has been provided by the DCS/Designee to the Social Services Director and the Licensed Nurses regarding ensuring that necessary/required areas on the Advanced Directives document are completed and that required signatures have been obtained and are on the document. The education also included the requirement that the most current code status be accurately determined and the physician's order accurately reflect code status. A review of Advanced Directives documents and physician's orders for code status will be completed by the DCS/Designee for (5) residents per week for (12) weeks to ensure that necessary/required areas on the

Advanced Directives document have been completed, that required signatures are present, the most current code status has been determined, and the most current physician's order accurately reflects code status .

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[] 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternative to that decision.

If you checked 2 above, check A, B, or C below:
[] A. While capable of making an informed decision, the patient has executed a written advanced directive which direct that life-prolonging procedures be withheld for withdrawn.
[] B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with the authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent of the Patient's is required.)
[] C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent of the Patient's Behalf is required)"

No boxes had been checked in either area of the DDNR.

Surveyor spoke with the RNC (regional nurse consultant) on 08/24/16 at approximately 1330 regarding the incorrect DDNR. RNC stated that the DDNR form was incomplete.

The concern of the incomplete DDNR was discussed with the administrative staff during a

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4. Results of the reviews conducted by the Director of Clinical Services/Designees will be reviewed at the Quality Assurance / Performance Improvement Committee Meeting each month for (three) months. The QAPI Committee will make recommendations for revisions to the plan as indicated to sustain substantial compliance. Once the QAPI Committee determines that the problem no longer exists, further review will be completed on a random basis.
5. 10/4/2016

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meeting on 08/23/16 at approximately 1630.

No further information was provided prior to exit.
2. For Resident #5, the facility failed to accurately complete a Virginia Department of Health DDNR (durable do not resuscitate) order and failed to accurately determine the Residents current code status.

The record review revealed that Resident #5 had been readmitted to the facility on 07/15/16. Diagnoses included, but were not limited to, sepsis, osteoarthritis, morbid obesity, heart failure, and chronic obstructive pulmonary disease.

Section C (cognitive status) of the Resident's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/22/16 included a BIMS (brief interview for mental status) score of 12 out of 15 points. Indicating the Resident was cognitively intact.

The Resident's clinical record included a physician signed (08/__/16) POS (physician order sheet) that indicated the Residents code status was a full code.

However, the front of the Residents clinical record included a DDNR order form that had been signed by the physician and the Residents POA (power of attorney). The date on this DDNR was documented as 07/21/16.

Under section 1 this DDNR read in part, "I further certify [must check 1 or 2]:
1. The patient is CAPABLE of making an informed decision...
2. The patient is INCAPABLE of making an

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informed decision..."
The boxes beside #1 and #2 had been left blank.

Under section 2 the DDNR box B had been checked. "While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn....

The bottom of this DDNR order form was signed by the physician and the POA (power of attorney).

The Residents CCP (comprehensive care plan) included the focus area "Resident has advanced directive r/t (related to) DNR."

The administrative staff were notified of the incomplete DDNR and inconsistencies in the Residents code status during an end of the day meeting with the survey team on 08/24/16 at approximately 3:20 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 241 SS=D 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

F 241

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

1. For Resident #1, there were no adverse effects. The physician and the responsible party have been notified. LPN #1 has received education regarding maintaining resident dignity during treatment administration. An observation has also been conducted by the DCS/Designee for

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Based on observation, staff interview and clinical record review, the facility staff failed to maintain dignity during wound care for 1 of 20 residents (Resident #1).

The findings included:

Resident #1 was originally admitted to the facility on 7/20/16. The resident was readmitted back into the facility on 7/8/16 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, peripheral vascular disease, neurogenic bladder, wound infection, quadriplegia, depression, bilateral above the knee amputation and pressure ulcer of the sacral region.

The resident was coded on the MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 6/27/16 with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was also coded as being totally dependent on 1 staff member for eating, dressing and personal hygiene.

The surveyor observed wound care being performed on 8/24/16 at approximately 10 a.m. Resident #1 ' s pressure ulcer was located on the resident ' s sacral area. After would care was performed by LPN #1, the nurse applied an occlusive dressing to the area. The nurse proceeded to write the date that the wound care was performed and signed her initials while the dressing was on the pressure ulcer on the Resident ' s sacral area.

LPN #1 was interviewed after the nurse had exited the room by the surveyor. The surveyor asked the nurse was it appropriate for her to date

LPN #1 during treatment administration to ensure that dignity is maintained during the procedure.

2. **LPN #1 has received education regarding maintaining resident dignity during treatment administration. An observation has also been conducted by the DCS/Designee for LPN #1 during treatment administration to ensure that dignity is maintained during the procedure. For resident's currently residing in the facility with pressure ulcers, a treatment observation has been completed by the DCS/Designee to ensure that dignity is maintained during the treatment.**
3. **Education has been completed by the DCS/Designee with currently employed Licensed Nurses regarding maintaining dignity during resident treatment administration to include dating and signing the new dressing before applying the dressing to the resident. Treatment observations will be conducted by the DCS/Designee with (3) Licensed Nurses per week for (12) weeks to ensure that dignity is maintained during the treatment including signing and dating the new dressing before it is applied to the resident.**

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and initial the sacral dressing once it was applied to the resident. LPN #1 stated, " No, it wasn ' t. I knew better than to do that. "

The regional nurse was notified of the above documented observation made by the surveyor during wound care. The regional nurse stated, " That ' s a dignity issue and we will do education with that nurse right now. "

The administrator, regional nurse and interim director of nursing were notified of the above documented findings. The regional nurse stated that education had already begun with all nurses concerning this matter.

No further information was provided to the surveyor prior to the exit conference on 8/24/16.

F 252 483.15(h)(1)
SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident and family interview, and in the course of a complaint investigation, the facility staff failed to ensure a clean and comfort homelike environment for 3 of 20 residents (Resident #10, #3 and #16).

The findings included:

F 241

4. **Results of the observations conducted by the Director of Clinical Services/ Designees will be reviewed at the Quality Assurance/Performance Improvement Committee Meeting each month for (three) months. The QAPI Committee will make recommendations for revisions to the plan as indicated to sustain substantial compliance. Once the QAPI Committee determines that the problem no longer exists, further review will be completed on a random basis.**
5. **10/4/2016**

F 252

1. **Regarding Resident #10's concerns, the shower room on Unit 1 was cleaned during the survey process. This included removing the cotton balls from the floor, picking up and sanitizing the (4) handheld water sprayers from the floor, removing the (3) bottles of shampoo from the floor, and cleaning the red/brown material from the commode. For Resident #3,**

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1. Resident #10 verbalized to the surveyor that the " hole " (referring to the shower room) was dirty and he would not take a shower in there.

Resident #10 was admitted to the facility on 10/28/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, stroke, dementia, anxiety and depression. On the resident ' s MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 6 out of 15. Resident #10 requires set up help only for dressing and bathing.

During the resident interview with Resident #10 on 8/24/16 at approximately 1 pm, the surveyor asked the resident if he liked to take showers or preferred to wash off in his room. The resident stated, " Have you been down there to the hole where they take us for a shower? I would rather not take one if I had to take one in there. " The surveyor asked the resident if the " hole " that he was referring to was the shower room. The resident stated, " Yes. " The surveyor verbalized to the resident that the surveyor would go down to the shower room to make an observation. The resident stated " I wish you would. "

The surveyor went to the shower room and was accompanied by Licensed Practical Nurse #2. Upon observation of the shower room, the surveyor noted the following: cotton balls were on the floor wet and observed randomly throughout the shower room, 4 hand held water sprayers were noted to be in the floor with the water still running, there were 3 bottles of shampoo in the floor and in the commode in the shower room was a reddish-brown dried

the room and the bathroom were cleaned during the survey process. The urine odor was eliminated, the red/brown substance was cleaned off of the back of the commode, lint was removed from the floor underneath the window. The pieces of paper and the 2x2 gauze were also removed from the floor. For Resident # 16, the resident room was also cleaned during the survey process. Resident #16 no longer resides in the center.

2. **Facility rounds including shower rooms, resident rooms and bathrooms have been conducted by the ED/ Designee to identify other environmental concerns. Further identified concerns were corrected as indicated by the results of the facility rounds.**
3. **Education has been conducted by the ED/Designee with current employees regarding identification of and notification to the appropriate persons regarding environmental concerns to include shower rooms, resident rooms, and bathrooms. Education also included keeping these areas clean. Facility rounds /observations including the shower rooms, resident rooms, and resident**

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substance. LPN #2 stated " This shower room has been busy all day. Someone should had cleaned up after they were finished. " The surveyor asked LPN #2 if this room appeared to be inviting and clean to the residents that used this shower room. LPN #2 stated " No, it doesn ' t. "

The interim administrator, regional nurse and interim director of nursing were notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference.

THIS IS A COMPLAINT DEFIENCY.
2. For Resident #3, the facility staff failed to ensure a clean and comfortable homelike environment in the resident's room and bathroom.

The record review revealed that Resident #3 had been admitted to the facility 05/29/10. Diagnoses included, but were not limited to, mild intellectual disabilities, dysphagia, peripheral vascular disease, hypothyroidism, and convulsions.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/08/16 had included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points.

On 08/23/16 at approximately 1:55 p.m. the surveyor completed an observation of the resident's bathroom. The bathroom was noted to have a strong odor of urine. The commode had been flushed and the resident did not have a roommate.

bathrooms will be conducted by the ED/Designee weekly for (12) weeks to identify environmental concerns as well as to ensure that cleaning is occurring.

4. **The results of the facility rounds /observations will be discussed by the ED/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan to sustain substantial compliance.**
5. **10/4/2016**

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On 08/25/16 at approximately 9:30 a.m. the surveyor completed a second observation of the resident's bathroom. The surveyor was able to observe a large amount of a brownish/reddish substance on the back of the commode. The bathroom still had a pervasive odor of urine. Upon exiting the bathroom and walking toward the resident's window the surveyor was able to observe lint on the floor underneath the window, pieces of paper scattered on the floor, and a 2 X 2 gauze lying in the floor.

During a group interview held with the residents of the facility on 08/24/16 at approximately 10:00 a.m. Resident #12 verbalized to surveyor #2 that she had to wait three days once to have her room cleaned. No problems were noted with Resident #12's room during the survey. Resident #12's BIMS score on their most recent MDS (07/14/16) was 15 out of 15 indicating the Resident was cognitively intact.

On 08/25/16 at approximately 9:05 a.m. the surveyor interviewed HKS (housekeeping staff) #1. HKS verbalized to the surveyor that the Resident rooms were cleaned daily. When asked if they were able to get their work completed HKS #1 stated yes, pretty much. When asked about any complaints regarding rooms not being clean HKS #1 stated not about me but that they had heard things about other staff not cleaning properly.

The administrative staff were notified of the above issues in Resident #3's room during a meeting with the survey team on 08/25/16.

No further information regarding this issue was

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provided to the survey team prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY

3. For Resident #16, the facility staff failed to ensure the Residents room was cleaned daily.

The record review revealed that Resident #16 was admitted to the facility 07/25/16. Diagnoses included, but were not limited to, acute kidney failure, cellulitis lower limb, anxiety, lymphedema, and heart failure.

Section C (cognitive patterns) of the Residents initial MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/01/16 included a BIMS (brief interview for mental status) score of 15 out of a possible 15 indicating the Resident was cognitively intact.

During an observation of Resident #16's room on 08/24/16 at approximately 1:20 p.m. the surveyor was able to observe an odor of urine in the room and several wet and dry pieces of napkins/tissues laying about in the floor beside the Residents bed.

During a second observation during the morning hours of 08/25/16 the surveyor was again able to observe debris such as napkins scattered throughout the floor next to the Residents bed, linen piled onto a chair that fell over into the floor, this was removed from the room by a staff person. There was also a moderate amount of a white substance on the table and in the floor of the room.

During a group interview held with the Residents

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of the facility on 08/24/16 at approximately 10:00 a.m. Resident #12 verbalized to surveyor #2 that she had to wait three days once to have her room cleaned. No problems were noted with Resident #12's room during the survey. Resident #12's BIMS score on their most recent MDS (07/14/16) was 15 out of 15 indicating the Resident was cognitively intact.

On 08/25/16 at approximately 9:05 a.m. the surveyor interviewed HKS (housekeeping staff) #1. HKS verbalized to the surveyor that the Resident rooms were cleaned daily. When asked if they were able to get their work completed HKS #1 stated yes, pretty much. When asked about any complaints regarding rooms not being clean HKS #1 stated not about me but that they had heard things about other staff not cleaning properly.

During an interview with Resident #16 on 08/25/16 at approximately 10:15 a.m. Resident #16 was asked if housekeeping cleaned her room daily. Resident #16 verbalized to the surveyor that her room was cleaned every other day.

The administrative staff were notified of the above issues in Resident #16's room during a meeting with the survey team on 08/25/16.

No further information regarding this issue was provided to the survey team prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY.

F 272 SS=D 483.20(b)(1) COMPREHENSIVE ASSESSMENTS — F 272

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F 272	Continued From page 12 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 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.	F 272	1. Resident #11, #6, and Resident #7 Section V of the Care Area Assessment (CAA) Summary have had the location and date of the CAA documentation of where the supportive information could be found has now been added to the V0200 Location and Date of the CAA documentation. 2. The facility had reviewed section V of resident's who still reside in the facility and the location and date of the supportive CAA documentation will be added to the location and date summary column as it appears on the individual CAT worksheets 3. The Regional MDS consultant has completed education with the facility MDSC on section V and the RAI rules along with F tag F272. Going forward the facility will add the location and date of supportive documentation on the CAA summary	

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This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record, the facility staff failed to ensure an accurate comprehensive MDS (Minimum Data Set) for 3 of 20 residents (Resident #11, #6 and #7).

The findings included:

1. The facility staff failed to ensure an accurate comprehensive MDS assessment for Resident #11.

Resident #11 was admitted to the facility on 10/2/15 with the following diagnoses of, but not limited to high blood pressure, thyroid disorder, seizures, depression, schizophrenia and severe intellectual disabilities. The resident was coded on the MDS with an AR (Assessment reference Date) of 6/15/16 as having a BIMS (Brief Interview for Mental Status) score of 1 out of a possible score of 15, in Section C, Cognitive Patterns.

The surveyor also reviewed Section V, Care Area Assessment (CAA) Summary. The facility staff did not identify the location and date of the CAA documentation of where it could be found. The only documentation noted in this area stated " CAA WS (worksheet) dated 6/20/16.

The MDS coordinator was interviewed on 8/24/16 at 2 pm. The MDS Coordinator stated that this was how she was taught to document in this area.

The administrator, regional nurse and the interim director of nursing were notified of the above documented findings on 8/24/16 at 4:30 pm.

column for comprehensive assessments. The facility DCS/Designee will review\ five (5) comprehensive assessments section V. Care Area Assessment (CAA) monthly to ensure the location and date of the supportive documentation is located on the V. CAA Location and date column.

4. The results of the review will be discussed by the DCS/Designee monthly for three (3) months at the Quality Assurance Performance Improvement Committee meeting. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.

5. 10/4/2016

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Np further information was provided to the surveyor prior to the exit conference.

2. For Resident #6 the facility staff failed to ensure an accurate comprehensive MDS (minimum data set) assessment.
Resident #6 was admitted to the facility on 05/25/12 and readmitted on 09/01/15. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, peripheral vascular disease, diabetes mellitus, hyperlipidemia, dementia, dysphagia, hypothyroidism and psychotic disorder.
The most recent comprehensive MDS with and ARD (assessment reference date) of 02/20/16 coded the Resident as 3 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 dated 02/26/16".
The MDS coordinator was interviewed on 08/23/16 at approximately 1015. She stated that is how she had always done it.
The administrative staff was notified of the findings during a meeting on 08/23/16 at approximately 1630.
No further information was provided prior to exit.

3. For Resident #7 the facility staff failed to ensure an accurate comprehensive MDS assessment.
Resident #7 was admitted to the facility on06/18/15 and readmitted on 11/25/15. Diagnoses included but not limited to anemia, urinary tract infection, Alzheimer's disease, dementia, malnutrition, anxiety, depression,

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F 272	Continued From page 15 dysphagia, coronary artery disease and hip fracture. The most recent comprehensive MDS with an ARD of 12/02/15 coded the Resident as 12 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 dated 12/03/15" . The MDS coordinator was interviewed on 08/23/16 at approximately 1015. She stated that is how she had always done it. The administrative staff was notified of the findings during a meeting on 08/23/16 at approximately 1630. No further information was provided prior to exit.	F 272		
F 309 SS=E	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 Resident interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide the necessary care and services to attain or maintain the highest practicable wellbeing for 16 of 20 residents. Residents #3, #5, #12, #16, #20, #6, #7, #8, #1,	F 309	**1. -For Resident #3, the physician and the responsible party have been notified. -For Resident #5, the physician and the responsible party have been notified. -For Resident #12, the physician and the responsible party have been notified. -For Resident #16, the (physician's order for allegra transcribed to the MAR??). Resident #16 no longer resides in the center. The physician and the responsible party have been notified. -For Resident #20, the physician's and the responsible party have been notified. The physician was contacted for further intervention.**	

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#10, #11, #13, #15, #2, #9, and #14.

The findings included.

1. For Resident #3, the facility staff failed to (A) administer the Residents medications per the physicians orders and failed to (B) follow the facility bowel protocol.

The record review revealed that Resident #3 had been admitted to the facility 05/29/10. Diagnoses included, but were not limited to, mild intellectual disabilities, dysphagia, peripheral vascular disease, hypothyroidism, and convulsions.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/08/16 had a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points. Section G (functional status) was coded (3/3) to indicate the Resident required extensive assistance of two plus persons for toilet use. Section H (bladder and bowel) was coded (1/1) to indicate the Resident was occasionally incontinent.

The Residents current CCP (comprehensive care plan) included the focus areas of-
Has impaired skin integrity due to dandruff and at risk for altered bowel and bladder elimination history of constipation and irritable bowel syndrome.

(A) When reviewing the Residents MAR's (medication administration records) for July and August 2016 it was noted that the facility nursing staff had documented that the Residents depakote (seizure medication) was not available

-For Resident #6, the physician and the responsible party have been notified. (The fall mats have been replaced at the bedside as indicated. Wander-guard function if being monitored.
-For Resident #7, the physician and the responsible party have been notified. Therapy has evaluated the resident for half side rail and hip abductor utilization.
-For Resident #8, the physician and the responsible party have been notified. Antihypertensive medications are currently being monitored per the physician's order.
-For Resident #1, bowel movements are currently being monitored and documented.
-For Resident #10, bowel movements are currently being monitored and documented.
-For Resident #11, bowel movements are currently being monitored and documented.
-For Resident #13, bowel movements are currently being monitored and documented.
-For Resident #15, bowel movements are currently being monitored and documented.
-For Resident #2, bowel movements

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for administration on 08/17/16 at 5:00 p.m. A review of the stat box list provided to the surveyor by the facility staff indicated that this medication would have been available in the stat box for administration.

Further review of the clinical record indicated that there was no documentation on the Residents MAR's (medication administration records) for July and August 2016 indicating the following medications and nutritional supplement had not been administered per the physician orders.

July 2016.
Prostat July 13 at 9:00 a.m.
Levothyroxine and Omeprazole on July 25 at 6:30 a.m.

For August 2016.
Levothyroxine and Omeprazole for August 1 and 2 at 6:30 a.m.
Hydrocodone August 3 at 6:00 a.m. and 2:00 p.m.
Depakote August 11, 12, 14, 15, and 21 at 9:00 p.m.
Depakote and Loratadine on August 14 at 5:00 p.m.
Docusate and Ferrous Sulfate August 20 at 5:00 p.m.
Dilantin, Keppra, Vimpat, and Loratadine on August 21 at 9:00 p.m.
Hydrocodone on August 21 at 10:00 p.m.
Mighty Shakes August 20, 21, and 22 at 5:00 p.m.

A review of the Residents TAR's (treatment administration records) for August 2016 indicated that the facility staff had not documented that they applied the Residents dandruff shampoo twice a week as ordered by the physician on August 1, 8,

are currently being monitored and documented.
-For Resident #9, bowel movements are currently being monitored and documented.
-For Resident #14, bowel movements are currently being monitored and documented.

2. For current residents residing in the facility, a review of the Medication Administration Record, Treatment Administration Record, and bowel movement documentation for the previous (30) days has been conducted by the Director of Clinical Services/Designee to identify further concerns regarding medication administration and parameters per physician's order including heart rate and blood pressure, treatment intervention implementation including fall mats, wander-guard, side rails and hip abductors, oxygen saturation levels per physician's order, bowel movement documentation and physician notification/intervention in the instance of no bowel movements within (3) days.

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11, 15 and the 18.

The facility did supply the surveyor with copies of the narcotic sheets referencing the hydrocodone. Indicating the nursing staff had removed the hydrocodone from the narcotic drawer on August 3 at 6:00 a.m. and 2:00 p.m. and on August 21 at 9:00 p.m.

Prior to the exit conference on 08/25/16 the facility staff did not provide the survey team with any evidence to indicate the above medications, treatments, and/or nutritional supplements were provided and administered per the physician orders and/or plan of care.

THIS IS A COMPLAINT DEFICIENCY.

1(b). The Residents ADL (activity of daily living) tracking form for July 2016 indicated that Resident #3 had BMs (bowel movements) on July 9, 14, 22, 29 and 30.

A review of the Residents current physician orders indicated the Resident was receiving Docusate Sodium (colace) 100 mg 1 cap twice daily for constipation.

The facility staff provided the survey team with a copy of their policy/procedure titled "Bowel Movement Assessment." This policy/procedure read in part. "...The Clinical Nurse checks the Bowel Movement Worksheet or ADL sheet for the date of the resident's last bowel movement and identifies the need for additional interventions. If the resident had not had a bowel movement by the third day, he/she is given a laxative or suppository, depending on the circumstances and physicians orders. The nurse checks the

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3. Education has been provided by the DCS/Designee to the Licensed Nurses regarding administration of medications per the physician's orders, monitoring parameters for medications including heart rate and blood pressure and documentation of parameters per the physician's orders, treatment intervention implementation documentation including fall mats, wander-guard, side rails, hip abductors, oxygen saturation levels obtained per physician's orders, and bowel movement documentation including physician notification/intervention in the instance of no bowel movement within (3) days. A review will be conducted by the DCS/Designee of the medical record, Medication Administration Record, Treatment Administration Record, and bowel movement records (2) times per week for (3) months to ensure that medications are administered per the physician's order, parameters including heart rate and blood pressure are monitored per the physician's order, treatment interventions are documented per the physician's order including fall

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resident's order sheet making sure there is a laxative or suppository order."

During a meeting with the administrative staff on 08/24/16 at approximately 3:20 p.m. the surveyor asked if the facility had any further information regarding the Residents BM's.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #5, the facility staff failed to administer medications and obtain oxygen saturations as ordered by the physician.

The record review revealed that Resident #5 had been readmitted to the facility on 07/15/16. Diagnoses included, but were not limited to, sepsis, osteoarthritis, morbid obesity, heart failure, and chronic obstructive pulmonary disease.

Section C (cognitive status) of the Resident's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/22/16 included a BIMS (brief interview for mental status) score of 12 out of 15 points. Indicating the Resident was cognitively intact.

The Residents clinical record included a physician signed (08/__/16) POS (physician order sheet) that included the orders O2 (oxygen) saturation every shift.

The Residents TAR (treatment administration record) read O2 sat (saturation) every shift as needed for SOB (shortness of breath)/change in condition. The TAR did not include any O2

matts, wander-guard, side rails, hip abductors, oxygen saturation levels per the physician's order, and bowel movements are documented with intervention as indicated per the physician's order.

4. **Results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee (QAPI) meeting monthly for (3) months. The committee will recommend revisions \ to the plan as indicated to sustain substantial compliance.**
5. **10/4/2016**

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saturations for the entire month of August 2016.

There was no documentation on the Residents MAR's (medication administration records) for August 2016 indicating the following medications had been administered per the physician orders.
Potassium (KCL) August 14 at 9:00 p.m. and August 17 at 2:00 p.m.
Diltiazen August 10 at 9:00 a.m.
Oxycodone August 8 at 6:00 a.m.

A review of the narcotic sheet for August 8 indicated that the facility nursing staff had documented they had removed the Oxycodone from the narcotic drawer at 6:00 a.m.

The administrative team were notified of the above issues during a meeting with the survey team on 08/25/16.

Prior to the exit conference on 08/25/16 the facility staff did not provide the survey team with any evidence to indicate the above medications, treatments, and/or nutritional supplements were provided and administered per the physician orders and/or plan of care.

THIS IS A COMPLAINT DEFICIENCY.

3. For Resident #12, the facility staff failed to administer the Residents medications as ordered by the physician.

The record review revealed that Resident #12 was admitted to the facility 10/25/12. Diagnoses included, but were not limited to, multiple sclerosis, abnormal posture, hyperlipidemia, atrial fibrillation, and hypertension.

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Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/14/16 included a BIMS (brief interview for mental status) score of 15 out of a 15 points. Indicating the Resident was cognitively intact.

During an interview with Resident #12 on 08/25/16 at approximately 8:20 a.m. Resident #12 verbalized to the surveyor that a couple of months ago she had a problem with getting her medications and that this mostly happened in the evenings.

There was no documentation on the Residents MAR's (medication administration records) for July and August 2016 indicating the following medications/treatments had been administered per the physician orders.

July 2016-
Metoprolol Tartrate July 10 at 5:00 p.m.
Atorvastatin on July 10 at 9:00 p.m.
Eucerin calming cream on July 9, 10, 22, and 29 on the 3-11 shift.
Voltaren gel July 7, 8, 9, 10, 15, and 29 on the 3-11 shift.

August 2016-
Diltiazem on August 9 at 9:00 a.m.

The administrative team were notified of the above issues during a meeting with the survey team on 08/25/16.

Prior to the exit conference on 08/25/16 the facility staff did not provide the survey team with any evidence to indicate the above medications or treatments were provided and administered

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per the physician orders and/or plan of care.

THIS IS A COMPLAINT DEFICIENCY.

4. For Resident #16, the facility staff failed to transcribe an order for allegra onto the Residents MAR (medication administration record) which resulted in the Resident not receiving the medication per the physician order.

The record review revealed that Resident #16 was admitted to the facility 07/25/16. Diagnoses included, but were not limited to, acute kidney failure, cellulitis lower limb, anxiety, lymphedema, and heart failure.

Section C (cognitive patterns) of the Residents initial MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/01/16 included a BIMS (brief interview for mental status) score of 15 out of a possible 15 points indicating the Resident was cognitively intact.

The Residents clinical record included a physician order dated 08/19/16 for "Allegra 24 hr 60 mg tab one po (by mouth) daily X 10 days-allergies."

During the record review the surveyor was unable to locate this order on the Residents current MAR.

On 08/25/16 at approximately 6:35 a.m. the surveyor asked LPN (licensed practical nurse) #1 to review the order and MAR. After reviewing the MAR LPN #1 verbalized to the surveyor that the order for the allegra was not on the MAR.

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On 08/25/16 at approximately 10:20 a.m. the surveyor asked LPN #2 about the allegra. LPN #2 verbalized to the surveyor that she had not given Resident #16 any allegra. When asked to check and see if the pharmacy had sent any to the facility LPN #2 verbalized to the surveyor that the allegra was a stock medication and would not have come from the pharmacy.

The administrative team were notified of the above issues during a meeting with the survey team on 08/25/16.

The facility policy/procedure titled "Physician Orders" read in part "A Clinical Nurse shall transcribe and review all physician orders in order to effect their implementation...The order must then be transcribed to all appropriate areas (MAR...)."

No further information regarding the allegra was provided to the survey team prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY.

5. For Resident #20, (A) administer the Residents medications per the physicians orders and failed to (B) follow the facility bowel protocol.

The record review revealed that Resident #20 was admitted to the facility 09/07/09. Diagnoses included, but were not limited to, dementia, dysphagia, atrial fibrillation, anemia, and hypertension.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of

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07/11/16 included a BIMS (brief interview for mental status) score of 2 out of a possible 15 points. Section G (functional status) was coded (3/2) to indicate the Resident required extensive assistance of one person for toilet use. Section H (bladder and bowel) was coded (2/2) to indicate the Resident was frequently incontinent of bowel and bladder.

(A) When reviewing the Residents MAR's (medication administration records) for August 2016 the surveyor was unable to find any documentation to indicate the following medications and/or nutritional supplements had been administered per the physicians order.

Gabapentin and Mirtazapine for August 1 and 5 at 9:00 p.m.
UTI Stat August 16 at 9:00 a.m.
Magic Cup August 16 at 12 p.m.
Med pass August 16 at 1:00 p.m.

Prior to the exit conference on 08/25/16 the facility staff did not provide the survey team with any evidence to indicate the above medications, treatments, and/or nutritional supplements were provided and administered per the physician orders and/or plan of care.

THIS IS A COMPLAINT DEFICIENCY.

5(b). The Residents current CCP (comprehensive care plan) included the focus area at risk for altered elimination related to history of chronic constipation, history of colon cancer with partial colectomy, and history of laxative abuse.

The Resident was currently receiving polyethylene glycol powder daily and senexon-s

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twice a day for constipation.

The Residents ADL (activity of daily living) tracking form for July 2016 indicated that Resident #20 had BMs (bowel movements) on July 3, 4, 7, 8, 13, 14, 29, and 30.

The facility staff provided the survey team with a copy of their policy/procedure titled "Bowel Movement Assessment." This policy/procedure read in part. "...The Clinical Nurse checks the Bowel Movement Worksheet or ADL sheet for the date of the resident's last bowel movement and identifies the need for additional interventions. If the resident had not had a bowel movement by the third day, he/she is given a laxative or suppository, depending on the circumstances and physicians orders. The nurse checks the resident's order sheet making sure there is a laxative or suppository order."

The administrative team were notified of all the above issues during a meeting with the survey team on 08/25/16.

No further information regarding this issue was provided to the survey team prior to the exit conference.

6. For Resident #6 the facility staff failed to follow physician's orders for the administration of the thyroid medication Levothyroxine and acetaminophen and for the treatments fall mats at bedside, and check wanderguard function.

Resident #6 was admitted to the facility on 05/25/12 and readmitted on 09/01/15. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, peripheral vascular disease, diabetes mellitus, hyperlipidemia,

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dementia, dysphagia, hypothyroidism and psychotic disorder.
The most recent comprehensive MDS with and ARD (assessment reference date) of 02/20/16 coded the Resident as 3 of 15 in Section C, cognitive patterns.

Resident #6's clinical record was reviewed on 08/23/16. It contained a signed POS (physician's order summary) dated 04/01/16 which read in part "Levothyroxine 175mcg tablet for levothyroxine sodium-take 1 tab by mouth every day for hypothyroidism" and "acetaminophen 325mg tablet for Tylenol 2 tabs (650mg) by mouth twice daily for pain". The Resident's clinical record also contained an MAR (medication administration record) which read in part "Levothyroxine 175mcg tablet for levothyroxine sodium-take 1 tab by mouth every day for hypothyroidism". This entry had not been initialed as having been administered on the following days: 04/10-14, 04/19-20, 04/22-26, and 04/28-29. The MAR also contained an entry which read in part "acetaminophen 325mg tablet for Tylenol 2 tabs (650mg) by mouth twice daily for pain". This entry had not been initialed as having been given on 04/11-12 at 5pm.

Resident #6's clinical record contained a signed POS dated 08/01/16 which contained the following entries: "Wanderguard-check function and expiration every shift and as needed" and "fall mats to floor when in bed". The Resident's TAR (treatment administration record) for the months of May, June, and July contained entries which read in part "wanderguard-check function and expiration every shift and as needed" and "fall mats to floor when in bed". The entry for the wanderguard had not been initialed as having

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been checked on the following dates: 05/4-5, 05/25, 05/27, 06/19-20, 06/27-29, all for 3-11 shift. The entry for fall mats had not been initialed as having been done on the following dates: 05/4-5, 05/25, 05/27, 06/02, 06/4-5 for 3-11 shift and 06/20, 06/23-24, 06/27-29, 07/11, 07/25, and 07/29-30 on 11-7 shift.

The concern of the missing documentation of medication and treatment administration was brought to the attention of the administrative staff during a meeting on 08/23/16 at approximately 1630. The RNC (regional nurse consultant) stated that they could not confirm that the medications/treatments had been completed as ordered.

No further information was provided prior to exit.

7. For Resident #7 the facility staff failed to follow physician's orders for the antianxiety medications trazodone and ativan, pain medications hydrocodone and ibuprofen, and peri-dex mouthwash, the supplements magic cup, uti-stat, medpass, and protein gelatin and the treatments half side rails and hip abductor.

Resident #7 was admitted to the facility on 06/18/15 and readmitted on 11/25/15. Diagnoses included but not limited to anemia, urinary tract infection, Alzheimer's disease, dementia, malnutrition, anxiety, depression, dysphagia, coronary artery disease, and hip fracture.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/25/16 coded the Resident as 12 of 15 in section C, cognitive patterns. This is a quarterly MDS.

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Resident #7's clinical record was reviewed on 08/23/16. It contained a signed POS (physician's order summary) dated 08/01/16 which read in part "lorazepam 0.5mg tablet for Ativan-take 1/2 tab (0.25.mg) by mouth every morning", "Peri-Dex mouthwash 15cc q8 (every 8 hours) x 7 days", trazodone 50mg tablet for Desyrel U-D-take 1/4 tab (12.5mg) by mouth every evening (4pm) for depression/anxiety", "lorazepam 0.5mg....take 1 tab by mouth every evening for anxiety", hydrocodone-acetaminophen 5-325mg tablet for Norco-take 1 tab by mouth every 6 hours for pain", ibuprofen 400mg tablet for Motrin-take 1 tab by mouth every 6 hours for pain", trazodone hcl 50mg....take 1/2 tab (25mg) by mouth at bedtime for depression/sundowning", "uti-stat 30cc (1oz) by mouth twice daily", protein gelatin twice daily as supplement for weight loss", "magic cup by mouth three times daily with meals", "medpass: take 90ml (3oz) four times daily as supplement for weight loss" and "1/2 bed side rails for increased bed mobility".

Resident #7's MAR (medication administration record) for the month of July was reviewed and contained the following entry which read in part "trazodone 50mg tablet...take 1/4 tab by mouth every evening..." This entry had not been initialed as having been administered on 07/4 or 07/21. The MAR contained an entry which read in part "hydrocodone-acetaminophen 5-325mg tablet...take 1 tab by mouth every 6 hours for pain". This entry had not been signed as having been administered on 07/19-21 at 12pm, 07/29 at 6am or 12am. The MAR contained an entry which read in part "ibuprofen 400mg tablet...take 1 tab by mouth every 6 hours for pain". This entry had

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not been initialed as having been administered on 07/21 at 12pm, 07/29 at 6am or 12am. The MAR contained an entry which read in part "trazodone hcl 50mg....take 1/2 tab (25mg) by mouth at bedtime...". This entry had not been signed as having been administered on 07/10. The MAR contained an entry which read in part "ativan 0.25mg 1 po q9A for anxiety". This entry had not been signed as having been administered on 07/28. The MAR contained an entry which read in part "ativan 0.25mg take 2 tabs po q5pm for anxiety". This entry had not been signed as having been administered on 07/18. The MAR contained an entry which read in part "Peridex mouthwash 15cc q8 hours x 7 days". This entry had not been initialed as having been administered on 07/28-29 at 6am, 07/27-29 at 2pm or 07/29 at 10pm. The MAR contained an entry which read in part "Magic Cup by mouth three times a day with meals". This entry had not been signed as having been administered on 07/28 and 07/30 at 9am and 1pm, and 07/06 and 0710 at 5pm. The MAR contained an entry which read in part "UTI-Stat 30cc (1oz) by mouth twice daily". This entry had not been signed as having been administered on 07/28 at 9am and 07/04, 07/06, 07/20-31 at 9pm. The MAR contained an entry which read in part "Medpass: Take 90ml (3oz) four times daily as supplement for weight loss". This entry had not been signed as having been administered on 07/28 at 9am or 1pm, 07/30 at 1pm, 07/06 and 07/10 at 5pm or 9pm, and 07/31 at 9pm. The MAR contained an entry which read in part "Protein gelatin twice daily as supplement for weight loss". This entry had not been signed as having been administered on 07/28 at 9am, 07/06 and 07/10 at 5pm.

Resident #7's TAR (treatment administration

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record) contained an entry which read in part " 2 1/2 side rails for increased bed mobility". This entry had not been signed on 07/23, 07/29 and 07/30 for 7-11, 07/5-6, 07/08-10, 07/ 23-24, and 07/29 for 3-11, and 07/28-30 for 11-7. The TAR contained an entry which read in part "hip abductor in place at all times". This entry had not been signed as having been done on 07/10-11 on 7-3, 07/05, 07/08-11 on 3-11, and 07/04, 07/08-11 on 11-7.

The concern of the missing documentation of medication and treatment administration was brought to the attention of the administrative staff during a meeting on 08/23/16 at approximately 1630. The RNC (regional nurse consultant) stated that they could not confirm that the medications/treatments had been completed as ordered.

No further information was provided prior to exit.

8. For Resident #8 the facility staff failed to follow physician's orders for the antihypertensive medications lisinopril and metoprolol, cholesterol medication atorvastatin, Ultram, Eliquis, aspirin and lisinopril and for monitoring for the antihypertensive medication diltiazem.

Resident #8 was admitted to the facility on 02/22/15 and readmitted on 03/14/16. Diagnoses included but not limited to atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, aphasia, cerebrovascular accident, dementia, respiratory failure, and dysphagia.

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The most recent MDS (minimum data set) with and ARD (assessment reference date) of 08/02/16 coded the Resident as 0 of 15 in section C, cognitive patterns. This is an annual MDS.

Resident #8's clinical record was reviewed on 08/23/16. It contained a signed POS (physician's order summary) dated 08/01/16 which read in part "aspirin 81mg tablet-take 1 tab by mouth every day for prophylaxis", "diltiazem 24hr CD 180mg cap ER 24-take 1 cap by mouth every day for hypertension-hold for SBP (systolic blood pressure) </110 or HR (heart rate) <55", "lisinopril 5mg tablet-take 1 tab by mouth every day for hypertension", "tramadol hcl f/c 50mg tablet-take 1 tab by mouth every 8 hours for pain", "atorvastatin 40mg tablet-take 1 tab by mouth at bedtime for hyperlipidemia" "metoprolol 50mg tab ER 24hr- take 1 tab by mouth every morning for hypertension", " metoprolol 25mg tab ER 24hr-take 1 tab by mouth every evening for hypertension" and "Eliquis 2.5mg tablet-take 1 tab by mouth twice daily for hx (history of) CVA (cerebrovascular accident)".

Resident #8's MAR's (medication administration record) for the months of July and August were reviewed. The MAR for July contained an entry which read in part "diltiazem 24hr CD 180mg cap ER 24-take 1 cap by mouth every day for hypertension-hold for SBP (systolic blood pressure) </110 or HR (heart rate) <55". There were no recorded BP's or HR's on the following dates: 07/01-03, 07/16, or 07/30 and no recorded HR's on 07/07-08, 07/11, 07/16, 7/22, or 07/27. The MAR contained an entry which read in part "atorvastatin 40mg tablet-take 1 tab by mouth at bedtime for hyperlipidemia". This entry had not been signed as having been administered on

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07/06-07or 07/09. The MAR contained an entry which read in part "Ultram 50mg 1po (by mouth) q8h (every 8 hours) for pain". This entry had not been signed as having been administered on 07/11, 07/13, and 07/29 at 6am. The MAR contained an entry which read in part "Eliquis 2.5mg tablet-take 1 tab by mouth twice daily for hx CVA". This entry had not been signed as having been administered on 07/03 at 9am and 07/02, 07/05, 07/07, 07/10, 07/14, 07/18-19, 07/25, and 07/27-28 at 5pm.

The MAR for the month of August contained an entry which read in part "aspirin 81mg -take 1 tab by mouth every day for prophylaxis". This entry had not been signed as having been given on 08/09/16. The MAR contained an entry which read in part "metoprolol 25mg tab ER 24hr-take 1 tab by mouth every evening for hypertension". This entry had not been signed as having been administered on 08/21/16. The MAR contained an entry which read in part "metoprolol 50mg tab ER 24hr- take 1 tab by mouth every morning for hypertension". This entry had not been signed as having been given on 08/08/09/16. The MAR contained an entry which read in part "diltiazem 24hr CD 180mg cap ER 24-take 1 cap by mouth every day for hypertension-hold for SBP (systolic blood pressure) </110 or HR (heart rate) <55". There were no recorded BP's or HR's for the following dates: 08/21 and 08/23-24 and no recorded HR's on 08/09 and 0812-20. The MAR contained an entry which read in part "lisinopril 5mg tablet-take 1 tab by mouth every day for hypertension". This entry had not been signed as having been administered on 08/09/16.

The concern of the missing documentation of medication and treatment administration was

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brought to the attention of the administrative staff during a meeting on 08/23/16 at approximately 1630. The RNC (regional nurse consultant) stated that they could not confirm that the medications/treatments had been completed as ordered.

No further information was provided prior to exit.
9. The facility staff failed to monitor bowel movements for Resident #1.

Resident #1 was originally admitted to the facility on 7/20/16. The resident was readmitted back into the facility on 7/8/16 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, peripheral vascular disease, neurogenic bladder, wound infection, quadriplegia, depression, bilateral above the knee amputation and pressure ulcer of the sacral region.

The resident was coded on the MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 6/27/16 with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was also coded as being totally dependent on 1 staff member for eating, dressing and personal hygiene.

The clinical record was reviewed by the surveyor along with the ADL (Activities of Daily Living) sheets for the month of July, 2016. There was no bowel movement documentation noted for the following days: 7/2/16, 7/3/16. 7/4/16, 7/5/16, 7/6/16, 7/8/16, 7/11/16. 7/12/16. 7/13/16, 7/16/16, 7/17/16, 7/18/16, 7/19/16, 7/20/16, 7/25/16, 7/26/16, 7/27/16, 7/28/16, 7/30/16 and 7/31/16.

The July MAR (Medication Administration

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Record) was also reviewed by the surveyor. The resident was ordered " Glycolax Dissolve 1 packet in liquid and take by mouth every day for constipation. "

The interim director of nursing was interviewed on 8/24/16 and stated that this was the only way that bowel movements were being monitored.

The surveyor received a copy of the policy and procedure titled " Bowel Movement Assessment. " The policy stated " ...The Clinical Nurse checks the Bowel Movement Worksheet or ADL sheet for the date of the resident ' s last bowel movement and identifies the need for additional interventions. If the resident has not had a bowel movement by the third day, he/she is given a laxative or suppository, depending upon the circumstances and physician orders. The nurse checks the resident ' s order sheet making sure there is a laxative or suppository order. "

The administrative team was notified of the above documented findings on 8/24/16 at 4:30 pm.

No further information was provided to the surveyor prior to the exit conference.

10. The facility staff failed to monitor bowel movements or Resident #10.

Resident #10 was admitted to the facility on 10/28/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, stroke, dementia, anxiety and depression. On the resident ' s MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of

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6 out of 15. Resident #10 requires set up help only for dressing and bathing.

The clinical record was reviewed by the surveyor along with the ADL (Activities of Daily Living) sheets for the month of July, 2016. There was no bowel movement documentation noted for the following days: 7/1/16, 7/2/16, 7/3/16, 7/4/16, 7/6/16, 7/8/16, 7/11/16, 7/15/16, 7/16/16, 7/17/16, 7/18/16, 7/19/16, 7/20/16, 7/22/16, 7/23/16, 7/24/16, 7/25/16, 7/30/16 and 7/31/16.

The July MAR (Medication Administration Record) was also reviewed by the surveyor. The resident was ordered " Senekot-S Take 2 tabs by mouth twice daily for constipation. "

The interim director of nursing was interviewed on 8/24/16 and stated that this was the only way that bowel movements were being monitored.

The surveyor received a copy of the policy and procedure titled " Bowel Movement Assessment. " The policy stated " ...The Clinical Nurse checks the Bowel Movement Worksheet or ADL sheet for the date of the resident ' s last bowel movement and identifies the need for additional interventions. If the resident has not had a bowel movement by the third day, he/she is given a laxative or suppository, depending upon the circumstances and physician orders. The nurse checks the resident ' s order sheet making sure there is a laxative or suppository order. "

The administrative team was notified of the above documented findings on 8/24/16 at 4:30 pm.

No further information was provided to the surveyor prior to the exit conference.

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11. The facility staff failed to monitor bowel movements for Resident #11.

Resident #11 was admitted to the facility on 10/2/15 with the following diagnoses of, but not limited to high blood pressure, thyroid disorder, seizures, depression, schizophrenia and severe intellectual disabilities. The resident was coded on the MDS with an AR (Assessment reference Date) of 6/15/16 as having a BIMS (Brief Interview for Mental Status) score of 1 out of a possible score of 15, in Section C, Cognitive Patterns.

The clinical record was reviewed by the surveyor along with the ADL (Activities of Daily Living) sheets for the month of July, 2016. There was no bowel movement documentation noted for the following days: 7/1/16, 7/3/16, 7/4/16, 7/5/16, 7/6/16, 7/8/16, 7/18/16, 7/19/16, 7/20/16, 7/21/16, 7/25/16, 7/26/16, 7/27/16, 7/29/16, 7/30/16 and 7/31/16.

The July MAR (Medication Administration Record) was also reviewed by the surveyor. The resident was ordered " Senekot-S Take 2 tabs by mouth twice daily for constipation. "

The interim director of nursing was interviewed on 8/24/16 and stated that this was the only way that bowel movements were being monitored.

The surveyor received a copy of the policy and procedure titled " Bowel Movement Assessment. " The policy stated " ...The Clinical Nurse checks the Bowel Movement Worksheet or ADL sheet for the date of the resident ' s last bowel movement and identifies the need for additional

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interventions. If the resident has not had a bowel movement by the third day, he/she is given a laxative or suppository, depending upon the circumstances and physician orders. The nurse checks the resident ' s order sheet making sure there is a laxative or suppository order. "

The administrative team was notified of the above documented findings on 8/24/16 at 4:30 pm.

No further information was provided to the surveyor prior to the exit conference.

12. The facility staff failed to monitor bowel movements for Resident #13.

Resident #13 was originally admitted to the facility on 6/29/11 and then readmitted on 6/18/14 with the following diagnoses of, but not limited to anemia, high blood pressure, heart failure, Alzheimer ' s disease and dementia. Resident #13 was coded in the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/15/16 as having a BIMS (Brief Interview for Mental Status) score of 1 out of a possible score of 15.

The clinical record was reviewed by the surveyor along with the ADL (Activities of Daily Living) sheets for the month of July, 2016. There was no bowel movement documentation noted for the following days: 7/1/16, 7/2/16, 7/4/16, 7/5/16, 7/6/16, 7/7/16, 7/8/16, 7/18/16, 7/19/16, 7/20/16, 7/21/16, 7/25/16, 7/26/16, 7/27/16, 7/29/16, 7/30/16 and 7/31/16.

The interim director of nursing was interviewed on 8/24/16 and stated that this was the only way that bowel movements were being monitored.

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The surveyor received a copy of the policy and procedure titled " Bowel Movement Assessment. " The policy stated " ...The Clinical Nurse checks the Bowel Movement Worksheet or ADL sheet for the date of the resident ' s last bowel movement and identifies the need for additional interventions. If the resident has not had a bowel movement by the third day, he/she is given a laxative or suppository, depending upon the circumstances and physician orders. The nurse checks the resident ' s order sheet making sure there is a laxative or suppository order. "

The administrative team was notified of the above documented findings on 8/24/16 at 4:30 pm.

No further information was provided to the surveyor prior to the exit conference.

13. The facility staff failed to monitor bowel movements for Resident #15.

Resident #15 was admitted to the facility on 3/2/15 with the following diagnoses of, but not limited to anemia, Multiple Sclerosis, malnutrition, anxiety, dysphagia and gastrostomy. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/10/16 as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #15 is totally dependent on 2 staff members for dressing, personal hygiene and bathing.

The clinical record was reviewed by the surveyor along with the ADL (Activities of Daily Living) sheets for the month of July, 2016. There was no documentation noted for the following days:

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7/1/16, 7/2/16, 7/4/16, 7/5/16, 7/6/16, 7/7/16, 7/8/16, 7/17/16, 7/18/16, 7/19/16, 7/20/16, 7/21/16, 7/25/16, 7/26/16, 7/27/16, 7/29/16, 7/30/16 and 7/31/16.

The interim director of nursing was interviewed on 8/24/16 and stated that this was the only way that bowel movements were being monitored.

The surveyor received a copy of the policy and procedure titled " Bowel Movement Assessment. " The policy stated " ...The Clinical Nurse checks the Bowel Movement Worksheet or ADL sheet for the date of the resident ' s last bowel movement and identifies the need for additional interventions. If the resident has not had a bowel movement by the third day, he/she is given a laxative or suppository, depending upon the circumstances and physician orders. The nurse checks the resident ' s order sheet making sure there is a laxative or suppository order. "

The administrative team was notified of the above documented findings on 8/24/16 at 4:30 pm.

No further information was provided to the surveyor prior to the exit conference.
14. The facility staff failed to monitor bowel movements for Resident #2.

Resident #2 was admitted to the facility on 8/17/15 with diagnoses of end stage renal disease, aphasia, Guillian -Barre syndrome, hypertension, diabetes, insomnia, depression, coronary artery disease, stroke, urinary tract infection, peptic ulcer disease, and chronic osteomyelitis.

The current quarterly Minimum Data Set (MDS)

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with a reference date of 5/30/16 assessed the resident with a cognitive score of "11" of "15". The resident was able to communicate with with gestures. The resident was assessed requiring total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, hygiene, and bathing. The resident was assessed to have bowel and bladder incontinence.

The clinical record was reviewed. The bowel and bladder report was provided by the acting director of nursing (DON). The report contained daily documentation by the certified nursing assistants(CNAs) for bowel movements. The report for June 2016 contained the resident had no bowel movements for 6/16 through 6/28. The report for July 2016 was blank for 7/4, 7/13,7/27, and 7/28. The forms completed by the CNAs for July and kept in the clinical record were blank for 7/4,7/5, 7/7,7/9,7/10,7/11, 7/13, and from 715 through 7/29.

The DON stated this was the only way bowel function was monitored. The DON provided the facility policy for monitoring bowel function. The policy stated the resident should have interventions done when no bowel movement for 3 days with either oral or a suppository given. The policy also stated no blanks on the form and a zero to be noted when no bowel movement.

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m.

15. The facility staff failed to monitor bowel movements for Resident #9.

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Resident #9 was admitted to the facility on 4/12/13 with diagnoses of dementia, anxiety, depression, pseudobulbar affect, arthritis, dysphagia, and anemia.

The current quarterly Minimum Data Set (MDS) with a reference date of 7/26/16 assessed the resident with a cognitive score of "0" of "15". The resident was assessed requiring extensive assistance of 1 person for bed mobility, transfers. dressing, eating, toileting, bathing , and hygiene. The resident was assessed to be incontinent for bowel function.

The clinical record was reviewed. The bowel and bladder report was provided by the acting director of nursing (DON). The report contained daily documentation by the certified nursing assistants(CNAs) for bowel movements. The report for June 2016 contained the resident had no bowel movements for 6/8 through 6/14. The form completed by the CNAs was blank for 6/4, 6/5, 6/6, 6/9, 6/11, 6/12, and 6/13 . The report for July documented no bowel function for 6/19 through 6/28. The report for July 2016 was blank for 7/4, 7/8,7/27, and 7/28 and no bowel movement from 7/9 through 7/15.

The DON stated this was the only way bowel function was monitored. The DON provided the facility policy for monitoring bowel function. The policy stated the resident should have interventions done when no bowel movement for 3 days with either oral or a suppository given. The policy also stated no blanks on the form and a zero to be noted when no bowel movement.

The administrator, DON, and corporate nurse

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consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m.

16. The facility staff failed to monitor bowel movements for Resident #14.

Resident #14 was admitted to the facility on 8/10/15 with diagnoses of chronic constipation, depression, Vitamin B12 deficiency, hypertension, hearing loss, hypothyroidism, anxiety, stroke, congestive heart failure, and gastro-esophageal reflux disease.

The current significant change Minimum Data Set (MDS) with a reference date of 2/29/16 assessed the resident with a cognitive score of "11" of "15". The resident was assessed requiring extensive assistance of 1 person for bed mobility, transfers, dressing, toileting, bathing, and hygiene. The resident was assessed to have occasional incontinence.

The comprehensive care plan was reviewed. The resident had a problem listed for altered bowel and bladder elimination with interventions listed to monitor incontinent briefs every two hours and change as needed.

The clinical record was reviewed. The resident had physician orders for medications for constipation for Miralax17 gms every other day, Biscodyl 10mg daily, Milk of Magnesia 45ml every other day, and a stool softner 200mg twice daily.

The August ADL tracking form was reviewed. The form was blank for 8/6, 8/7, 8/19, and 8/21. The staff documented the resident did not have a bowel movement 8/17, 8/18, 8/19, 8/20, and 8/21.

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F 309	Continued From page 43 These included blanks. The DON stated this was the only way bowel function was monitored. The DON provided the facility policy for monitoring bowel function. The policy stated the resident should have interventions done when no bowel movement for 3 days with either oral or a suppository given. The policy also stated no blanks on the form and a zero to be noted when no bowel movement. The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, group of resident's review, staff interview, and clinical record review, and in the course of a complaint investigation, the facility staff failed to provide activities of daily living (ADLs) for bathing for 10 of 20 residents (Resident# 2, #9, #7, #12, #20, #3, #10, #11, #13, and #15). The findings include: 1. The facility staff failed to provide daily bathing	F 312	**1. Resident #2 is currently being bathed. Resident #9 is currently being bathed. Resident #7 is currently being bathed. Resident #3 is currently being bathed. Resident #12 is currently being bathed. Resident #20 is currently being bathed. Resident #10 is currently being bathed. Resident #11 is currently being bathed. Resident #13 is currently being bathed. Resident #15 is currently being bathed.** **2. For current resident's residing in the facility, interviews have been conducted by the DCS/Designee to establish resident preference regarding bathing. Bathing schedules have been revised as indicated by the interviews.** **3. Education has been provided by the e DCS/Designee to the nursing staff**	

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Resident #2 was admitted to the facility on 8/17/15 with diagnoses of end stage renal disease, aphasia, Guillian-Barre syndrome, hypertension, diabetes, insomnia, depression, coronary artery disease, stroke, urinary tract infection, peptic ulcer disease, and chronic osteomyelitis.

The current quarterly Minimum Data Set (MDS) with a reference date of 5/30/16 assessed the resident with a cognitive score of "11" of "15". The resident was able to communicate with with gestures. The resident was assessed requiring total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, hygiene, and bathing. The resident was assessed to have bowel and bladder incontinence. The resident was transported to dialysis via stretcher.

Two certified nursing assistants (CNAs) were interviewed on initial tour of the facility conducted 8/22/16 at 6:00 p.m. CNA#1 stated he was not always able to get his assigned bathing completed on the evening shift. The other CNA (CNA#2) stated she would stay late to get her work completed.

The resident was interviewed on 8/24/16 at 8:30 a.m. The resident was asked if he got his baths and he gestured with a thumbs down motion that he did not.

The ADL tracking form for July 2016 was reviewed. The resident was documented to receive a partial bath on 7/2, 7/3 , and 7/6. The rest of the form for July 1 through July 31 was incomplete or blank. The computerized bathing

regarding resident bathing and documentation of resident bathing preferences. The DCS/Designee will conduct a review for five (5) residents per week for three (3) months to ensure that baths are being completed and documented per the residents' preference.

4. **The results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.**
5. **10/4/2016**

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report provided by the acting director of nursing (DON) was blank for 7/4, 7/8, 7/13, 7/17, 7/27, 7/28, and 7/30. The resident was noted to receive 1 shower for the month on 7/20.

The DON stated this was the only method the facility had to document bathing.

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m.

2. The facility staff failed to provide bathing for Resident #9.

Resident #9 was admitted to the facility on 4/12/13 with diagnoses of dementia, anxiety, depression, pseudobulbar affect, arthritis, dysphagia, and anemia.

The current quarterly Minimum Data Set (MDS) with a reference date of 7/26/16 assessed the resident with a cognitive score of "0" of "15". The resident was assessed requiring extensive assistance of 1 person for bed mobility, transfers, dressing, eating, toileting, bathing , and hygiene.

The ADL tracking form for July 2016 was reviewed. The resident was documented to receive a partial bath on 7/6. and a bed bath on 7/30 and a shower on 7/30. The rest of the form for July 1 through July 31 was incomplete or blank. The computerized bathing report provided by the acting director of nursing (DON) was blank for 7/4,7/8, 7/17, 7/28, and 7/30. The resident was noted to receive 1 shower for the month on 7/30.

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The DON stated this was the only method the facility had to document bathing.

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/24/16 at 1:30 p.m.

3. For Resident #7 the facility staff failed to provide ADL (activities of daily living) assistance for bathing.

Resident #7 was admitted to the facility on 06/18/15 and readmitted on 11/25/15. Diagnoses included but not limited to anemia, urinary tract infection, Alzheimer's disease, dementia, malnutrition, anxiety, depression, dysphagia, coronary artery disease, and hip fracture.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/25/16 coded the Resident as 12 of 15 in section C, cognitive patterns. Section G, function status coded the Resident as 3 of 3 in the area of bathing, which is equivalent to "extensive assistance two person physical assist". This is a quarterly MDS.

Surveyor interviewed the Resident on 08/23/16 at 1400. Surveyor asked Resident #7 if she received her baths/showers as scheduled and she stated that she did not. She also stated that she "might get one a week if the girls have time". Resident stated that she had a bath the previous day due to having a doctor appointment this AM. Surveyor observed at the time of interview that Resident was neatly dressed in street clothes and appeared to be clean.

Resident #7's ADL sheets for bathing were

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reviewed on 08/23/16. The ADL sheets indicated that the Resident only received one partial bath and one bed bath from 06/02/16-06/07/16, five partial baths from 06/09/16-06/28/16, one partial bath and two bed baths from 06/30/16--7/05/16, four partial baths and three bed baths from 07/10/16-07/20/16 and three partial baths and one bed bath from 07/22/16-07/31/16.

The concern of not providing ADL care was discussed with the administrative staff during meeting on 08/23/16 at approximately 1630. The RNC (regional nurse consultant) stated that the facility had changed from electronically charting ADL care to paper charting due to the number of "agency staff" at the facility. RNC stated that they could not confirm that ADL's had been completed.

No further information was provided prior to exit.
4. For Resident #3, the facility staff failed to provide ADL (activities of daily living) care in the area of bathing.

The record review revealed that Resident #3 had been admitted to the facility 05/29/10. Diagnoses included, but were not limited to, mild intellectual disabilities, dysphagia, peripheral vascular disease, hypothyroidism, and convulsions.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/08/16 included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points. Section G (functional status) was coded (3/2) for personal hygiene extensive assistance of one person and (3/3) for bathing extensive assistance of 2 + persons.

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Resident #3's ADL tracking form indicated that Resident #3 had only received partial baths on July 2, 3, 6, 29, and 30 and a bed bath on July 9.

On 08/24/16 at approximately 11:10 a.m. RN (registered nurse) #3 verbalized to the survey team that they had hired a shower aide due to concerns from Residents and family members that the Residents of the facility were not getting their showers.

During a meeting with the administrative staff on 08/24/16 at approximately 3:20 p.m. the surveyor asked if the facility had any further information on the Residents bathing status.

No further information regarding this issue was provided to the survey team prior to the exit conference.

5. For Resident #12, the facility staff failed to provide ADL (activities of daily living) care in the area of bathing.

The record review revealed that Resident #12 was admitted to the facility 10/25/12. Diagnoses included, but were not limited to, multiple sclerosis, abnormal posture, hyperlipidemia, atrial fibrillation, and hypertension.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/14/16 included a BIMS (brief interview for mental stats) summary score of 15 out of a 15 points. Indicating the Resident was cognitively intact. Section G (functional status) was coded (3/2) for personal hygiene extensive assistance of one

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person and (3/3) for bathing extensive assistance of 2 + persons.

Resident #12's ADL tracking form indicated that Resident #12 had received partial baths on July 2, 3, 5 and 9. A bed bath on July 10 and a shower on July 14.

On 08/24/16 at approximately 11:10 a.m. RN (registered nurse) #3 verbalized to the survey team that they had hired a shower aide due to concerns from Residents and family members that the Residents of the facility were not getting their showers.

During an interview with Resident #12 on 08/24/16 at approximately 2:15 p.m. Resident #12 verbalized to the surveyor that she received one bath a week if at all. When asked if she was okay with that she stated not really.

The administrative staff were notified of the above in a meeting with the survey team on 08/24/16 at approximately 3:20 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

6. For Resident #20, the facility staff failed to provide ADL (activities of daily living) care in the area of bathing.

The record review revealed that Resident #20 was admitted to the facility 09/07/09. Diagnoses included, but were not limited to, dementia, dysphagia, atrial fibrillation, anemia, and hypertension.

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Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/11/16 included a BIMS (brief interview for mental status) summary score of 2 out of a possible 15 points. Section G (functional status) was coded was coded (3/2) for personal hygiene and bathing indicating the Resident required extensive assistance of one person.

Resident #20's ADL tracking form indicated that for July 2016 Resident #20 had received a partial bath on July 2, 29, and 30. A shower on July 4, 7, and 14 and a bed bath on July 15.

On 08/24/16 at approximately 11:10 a.m. RN (registered nurse) #3 verbalized to the survey team that they had hired a shower aide due to concerns from Residents and family members that the Residents of the facility were not getting their showers.

The administrative staff were notified of the above in a meeting with the survey team on 08/25/16.

No further information regarding the Residents bathing status was provided to the survey team prior to the exit conference.

7. The facility staff failed to provide daily bathing for Resident #10.

Resident #10 was admitted to the facility on 10/28/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, stroke, dementia, anxiety and depression. On the resident ' s MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/16 coded the resident as having a

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BIMS (Brief Interview for Mental Status) score of 6 out of 15. Resident #10 requires set up help only for dressing and bathing.

A clinical record review was conducted by the surveyor on 8/23/16. The ADL (Activities of Daily Living) from for July, 2016 were also reviewed. The resident was documented as to not have had a shower or bath from August 1 through August 14. However, the resident did receive a partial bath on 8/8/16.

On 8/24/16 at 4:30 pm, the administrative team was notified of the above documented findings. The regional nurse stated, " We had to go to paper charting in July because of the number of complaints that we were receiving of residents not getting their baths. I honestly cannot tell you if they received them or not. "

No further information was provided to the provided to the surveyor prior to the exit conference.

8. The facility staff failed to provide daily bathing for Resident #11.

Resident #11 was admitted to the facility on 10/2/15 with the following diagnoses of, but not limited to high blood pressure, thyroid disorder, seizures, depression, schizophrenia and severe intellectual disabilities. The resident was coded on the MDS with an AR (Assessment reference Date) of 6/15/16 as having a BIMS (Brief Interview for Mental Status) score of 1 out of a possible score of 15, in Section C, Cognitive Patterns.

The ADL tracking form for July, 2016 was reviewed. Resident #11 was documented as to

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have received a shower on 7/6/16. All the other dates in the month of July were either left blank or had " 8 " in the boxes which means the activity did not occur.

The director of nursing stated that this was the only way that bathing was being tracked in the facility. The director also stated that they have had to switch to paper charting in July due to the number of complaints that residents were not receiving their baths. " I honestly cannot tell you if they received their baths or not. "

On 8/24/16 at 4:30 pm, the administrative team was notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference.

9. The facility staff failed to provide daily bathing for Resident #13.

Resident #13 was originally admitted to the facility on 6/29/11 and then readmitted on 6/18/14 with the following diagnoses of, but not limited to anemia, high blood pressure, heart failure, Alzheimer ' s disease and dementia. Resident #12 was coded in the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/15/16 as having a BIMS (Brief Interview for Mental Status) score of 1 out of a possible score of 15.

A clinical record review was performed by the surveyor. On the ADL tracking form July. 2016, the resident received 2 partial baths. One was on 7/7/16 and the other one was 7/14/16. All of the other dates were left blank or had an " 8 " documented which means that the activity did not

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occur for this resident.

The director of nursing stated that this was the only way that bathing was being tracked in the facility. The director also stated that they have had to switch to paper charting in July due to the number of complaints that residents were not receiving their baths. " I honestly cannot tell you if they received their baths or not. "

On 8/24/16 at 4:30 pm, the administrative team was notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference.

10. The facility staff failed to provide daily bathing for Resident #15.

Resident #15 was admitted to the facility on 3/2/15 with the following diagnoses of, but not limited to anemia, Multiple Sclerosis, malnutrition, anxiety, dysphagia and gastrostomy. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/10/16 as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #15 is totally dependent on 2 staff members for dressing, personal hygiene and bathing.

A clinical review of Resident #15 ' s clinical record was reviewed by the surveyor. The ADL tracking form was also reviewed at this time. There were only 2 dates in July, 2016 that it was documented that the resident received 2 partial baths. The rest of the month, the boxes were either blank or had an " 8 " documented which means that the

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F 312	Continued From page 54 activity did not occur. The director of nursing stated that this was the only way that bathing was being tracked in the facility. The director also stated that they have had to switch to paper charting in July due to the number of complaints that residents were not receiving their baths. " I honestly cannot tell you if they received their baths or not. " On 8/24/16 at 4:30 pm, the administrative team was notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and in the course of a complaint investigation the facility staff failed to provide services to prevent pressure ulcers for 1 of 20 Residents, Resident #8. The findings included:	F 314	**1. For Resident, #8, the physician and the responsible party have been notified of the missing initials on the Treatment Administration Record for the month of May, June, and July 2016 as well as the missing initials on the Medication Administration Record for the month of June 2016.**	

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For Resident #8, the facility failed to follow physician's orders to prevent/treat pressure ulcers.

Resident #8 was admitted to the facility on 02/22/15 and readmitted on 03/14/16. Diagnoses included but not limited to atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, aphasia, cerebrovascular accident, dementia, respiratory failure, and dysphagia.

The most recent MDS (minimum data set) with and ARD (assessment reference date) of 08/02/16 coded the Resident as 0 of 15 in section C, cognitive patterns. Section M, skin conditions coded the Resident as being at risk for developing pressure ulcers, having unhealed pressure ulcers, having two stage 3 pressure ulcers not present on admission. This is an annual MDS.

Resident #8's clinical record was reviewed on 08/23/16. It contained a signed POS (physician's order summary) dated 05/04/16 which read in part "Sureprep to bilateral heels every shift". The clinical record also contained a TAR (treatment administration record) for the month of May 2016 which read in part "Sureprep to bilateral heels every shift". The MAR had not been initialed as completed on the following dates: 05/12 for 7-3, 05/18 for 7-3 or 3-11, 05/21-22 for 7-3 or 3-11, 05/23-25 for 3-11, and 05/31 for 7-3 or 3-11.

Resident #8's clinical record contained a signed physician's order dated 06/21/16 which read in part "moon boots on bil (bilateral) feet when in

2. For current residents residing in the center, the DCS/Designee has conducted a review of Medication Administration Records and Treatment Administration Records for the previous thirty (30) days to identify other interventions/medications that may have not been initialed off on the MAR/TAR. The physician and responsible party have been notified.

3. Education has been provided by the DCS/Designee to the Licensed Nurses regarding the six rights of medication and treatment administration including documentation of the administration. MARs and TARs

will be reviewed by the DCS/Designee to identify potential medications /interventions not administered as well as to ensure that documentation has been completed appropriately three (3) times weekly for three (3) months.

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bed, clean R (right) lat (lateral) ankle c (with) N/S (normal saline), apply Duoderm-change q (every) 3 days and prn (as needed), clean sacrum c NS apply Maxorb and cover c Optifoam q 3 days and as needed, Sureprep to (R) heel qd (every day) as preventative, clean (L) heel c NS apply Santyl oint c gauze dressing, wrap c Kling bid (twice daily), and air mattress to bed". The Resident's TAR for June 2016 contained entries which read in part "moon boots on bil (bilateral) feet when in bed, clean R (right) lat (lateral) ankle c (with) N/S (normal saline), apply Duoderm-change q (every) 3 days and prn (as needed), clean sacrum c NS apply Maxorb and cover c Optifoam q 3 days and as needed, Sureprep to (R) heel qd (every day) as preventative, clean (L) heel c NS apply Santyl oint c gauze dressing, wrap c Kling bid (twice daily), and air mattress to bed". There were multiple areas on the MAR which had not been initialed as the treatments having been completed. The TAR for the month of July contained an entry which read in part "cleanse L heel c NS pat dry apply Maxorb cover c dry dressing QD". This entry had not been initialed at any time as having been completed.

The surveyor spoke with the RNC (regional nurse consultant) on 08/23/16 at approximately 1050, regarding Resident #8. RNC stated that she could not confirm that the treatments had been completed as ordered.

The concern of the treatments not being completed was discussed with the administrative staff during a meeting on 08/23/16 at approximately 1630.

No further information was provided prior to exit. This is a complaint deficiency.

4. Results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.

5. 10/4/2016

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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 staff interview and clinical record review, the facility staff failed to provide services as ordered by the physician on 1 of 20 residents (Resident#1).

The findings included:

Resident #1 was originally admitted to the facility on 7/20/16. The resident was readmitted back into the facility on 7/8/16 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, peripheral vascular disease, neurogenic bladder, wound infection, quadriplegia, depression, bilateral above the knee amputation and pressure ulcer of the sacral region.

The resident was coded on the MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 6/27/16 with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was also coded as being totally dependent on 1 staff member for eating,

1. **For Resident #1, an appointment was scheduled to have the suprapubic catheter changed.**
2. **For residents currently residing in the facility with catheters, a review has been conducted by the DCS/Designee to ensure that catheters have been changed as ordered by the physician.**
3. **Education has been provided by the DCS/Designee to Licensed Nurses regarding ensuring that catheters are changed as ordered by the physician. The DCS/Designee will conduct a review for (3) residents per week for three (3) months to ensure that catheters have been changed as ordered by the physician.**
4. **The results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.**
5. **10/4/2016**

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dressing and personal hygiene.

The surveyor performed a clinical record review of Resident #1 ' s medical record. The following physician order was noted on the Plan of Care dated for 7/1/16 through 7/31/16 which stated, " ...Suprapubic tube to be changed monthly by urology. " This surveyor could not find documentation this had been done.

On 8/24/16 at 4:30 pm, the administrative team was notified of the above findings.

On 8/25/16 at 11 am, the regional nurse stated to the surveyor, " We cannot find any documentation that this has been done either. The nurses are making arrangements to have resident transferred to urology clinic to have it changed. "

No further information was provided to the surveyor prior to the exit conference.

F 315

F 328 SS=E 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.

F 328

1. Oxygen concentrator filters identified as dirty on Unit 1 and Unit 2 were corrected during the survey process including room 410. For Resident #15, the tube feeding is being administered as ordered by the physician.

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

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	495325	A. BUILDING _____ B. WING _____	C 08/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documents review, clinical record review, and in the course of a complaint investigation the facility staff failed to perform routine maintenance in regards to oxygen concentrators and failed to provide an enteral feeding as ordered by the physician for 1 of 20 Residents, Resident #15.

The findings included.

1. The facility staff failed to clean oxygen concentrators filters used by the residents of the facility.

On 08/24/16 at approximately 10:35 a.m. LPN (licensed practical nurse) #5 was interviewed regarding the changing/cleaning of oxygen filters. LPN #5 verbalized to the surveyor that the filters were changed as needed and she had been told that they had new filters so they didn't need to wash them anymore.

On 08/25/16 at approximately 6:05 a.m. the surveyor asked LPN #1 how often the filters on the oxygen concentrators were cleaned/changed. LPN #1 verbalized to the surveyor that they were cleaned every Sunday.

On 08/25/16 at approximately 6:10 a.m. LPN #3 verbalized to the surveyor that the oxygen filters were usually cleaned/changed on Sunday nights.

When interviewing an agency nurse working at the facility on 08/25/16 at approximately 6:15 a.m. agency nurse #1 verbalized to the surveyor that the filters on the back of the concentrators were cleaned every 30 days.

2. Residents currently residing in the facility that utilize oxygen have had the filters on their oxygen concentrators cleaned. Residents that reside in the facility with tube feeding have had their physician's orders reviewed. Observations of residents with tube feeding have been conducted by the DCS/Designee to ensure that tube feeding is provided as ordered by the physician.

3. Education has been provided by the DCS/Designee to Licensed Nurses regarding maintaining clean filters on oxygen concentrators as well as administering tube feeding as ordered by the physician. Observations will be conducted by the DCS/Designee three (3) times per week for three (3) months for three (3) residents to ensure that oxygen filters are clean and that tube feeding is being administered as ordered by the physician.

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In the morning of 08/25/16 the surveyor and the director of clinical services did a random check of oxygen filters. Of the three filters checked on unit 1-one was found to have a moderate amount of lint present. Of the three filters checked on unit 2-two were found with lint present. The filter in room 410 was observed with a large amount of lint.

On 08/25/16 at approximately 9:00 a.m. the surveyor attempted to check the oxygen filters in room 404 and 202 all of the filters had been removed from the concentrators. One of the residents in room 404 stated that the facility staff had removed the filters for cleaning.

On 08/25/16 at approximately 9:10 a.m. the surveyor interviewed RN (registered nurse) #3 regarding the missing filters. RN #3 verbalized to the surveyor that she had removed the filters for cleaning. When asked how they looked RN #3 stated the ones on the 200/300 hall looked like they had been cleaned. She then stated the ones on the 400 hall did not look like they had been cleaned. RN #3 was then asked the cleaning schedule for the filters RN #3 stated the filters should be rinsed weekly and one time a month a representative should come to the facility and clean the filters. RN #3 then added she wasn't sure when the representative came in and cleaned the filters.

The facility staff provided the surveyor with a copy of the service manual for the oxygen concentrators used at the facility. In regards to cleaning or replacing cabinet filters the manual did not specify a specific cleaning schedule but did read "Clean or replace gross particle (cabinet)

4. **The results of the observations will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.**
5. **10/4/2016**

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filters on both sides of the cabinet NOTE: Perform this procedure as needed depending upon the environment the concentrator is used in..."

The administrative staff were notified of the above on 08/25/16 prior to the exit conference.

No further information regarding the oxygen concentrator filters was provided to the survey team prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY.

2. The facility staff failed to restart the enteral feeding system to Resident #15.

Resident #15 was admitted to the facility on 3/2/15 with the following diagnoses of, but not limited to anemia, Multiple Sclerosis, malnutrition, anxiety, dysphagia and gastrostomy. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/10/16 as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #15 is totally dependent on 2 staff members for dressing, personal hygiene and bathing.

On initial tour of the facility on 8/22/16 at approximately 6:20 pm, the surveyor went into Resident #15 ' s room. The surveyor observed the feeding the draped over the IV pole but was not connected to the resident. The Surveyor asked the resident how long has it been that the feeding tube had not been restarted. Resident #15 stated, " Ever since I took my bath at 2 pm this afternoon. I have told different ones but it hasn ' t got done. "

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At 7:30 pm, the surveyor went back into the resident ' s room to observe if the feeding tube had been restarted. The surveyor noted the feeding tube in the same location as documented above.

At 8:30 pm, the surveyor once again, went into the resident ' s room and observed the feeding tube in the same manner in which it had been on the first 2 observations.

On 8/23/16 at approximately 8 am, the surveyor went into the resident ' s room. The resident was asleep but the feeding tube was infusing by IV pump.

At approximately 10 am, the surveyor returned to the resident ' s room and the resident stated, " They didn ' t reconnect my feeding tube until 9:20 pm last night. "

The surveyor reviewed the clinical record of Resident #15. On the Plan of Care, the physician had ordered the following: " Tube feed 2 CAL at 30cc/hr x 20 hours daily via (by) peg tube ... "

The administrative team was notified of the above documented findings at the end of the day conference on 8/23/16.

No further information was provided to the surveyor prior to the exit conference.

F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333	**1. For Resident #2, the physician and responsible party have been notified regarding the omitted initials for**

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure 4 of 20 residents (Resident #2, #4, #6, and #8) were free from significant medication error.

The findings include:

1. The facility staff failed to administer insulin per the physician order for Resident #2.

Resident #2 was admitted to the facility on 8/17/15 with diagnoses of diabetes, end stage renal disease, aphasia, Guillian -Barre syndrome, hypertension, insomnia, depression, coronary artery disease, stroke, urinary tract infection, peptic ulcer disease, and chronic osteomyelitis.

The current quarterly Minimum Data Set (MDS) with a reference date of 5/30/16 assessed the resident with a cognitive score of "11" of "15". The resident was able to communicate with with gestures. The resident was assessed requiring total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, hygiene, and bathing. The resident was assessed to have bowel and bladder incontinence.

The clinical record was reviewed. The physician ordered accuchecks (blood sugar monitoring) every 6 hours and also a sliding scale insulin schedule every 6 hours of Novolog 2 units for blood sugar(BS) of 200-249, 4 units for for BS 250-299, 6 units for BS 300-349, 8 units for BS 350-399, and greater than 399 12 units. The

Levemir insulin on 7/10/16, 7/12/16, 7/13/16, 7/14/16, 7/15/16, 7/26/16, 7/28/16, and 7/30/16. The physician and RP have also been notified regarding omitted initials for accu-checks for Resident #2 on 7/12/16 and 7/29/16. The physician and responsible party have been made aware of the medication variance for sliding scale insulin on 7/12/16 and 7/28/16.

For Resident #4, the physician \and responsible party have been notified regarding Novolg insulin that was held on 8/18/16 for a blood glucose level of 88 as well as Novolog with-held on 8/21/16 for a blood glucose level of 41 and the omitted blood glucose recheck as ordered by the physician. The physician and responsible party have also been notified of the blood glucose levels of 500 and 503 on 7/8/16. The physician and RP were also made aware of the omitted initials for Levemir insulin on 7/26/16.

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order was to call the physician for BS less than 60 or greater than 500. The physician also ordered to Levemir insulin 10 units every 12 hours.

The medication administration record (MAR) for July 2016 was reviewed. The facility staff failed to administer the Levemir insulin on 7/10, 7/12, 7/13,7/14,7/15, 7/26, and 7/29 at 9:00 p.m. The facility staff also failed to administer the Levemir at 9:00 a.m. on 7/26,7/28, and 7/30.

The facility staff also failed to obtain accuchecks on 7/12 at noon, and 7/29 at 6:00 a.m. and 12 midnight. The facility staff failed to administer the appropriate sliding scale insulin on 7/12 at noon, and at 6:00 a.m. and midnight on 7/28.

The director of nursing (DON) provided the survey team with copies of the facility policy on "Insulin Administration". The policy stated the "clinical nurse was to administer insulin subcutaneously per the physician order".

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m. There was no further information provided by the facility prior to exit.

2. The facility staff failed to follow physician orders for insulin administration for Resident #4.

Resident #4 was admitted to the facility on 2/18/15 and re-admitted on 5/24/16 with diagnoses of diabetes, paraplegia, urinary retention, malnutrition, chronic pulmonary embolism, hypertension, psychosis, anemia, gastro esophageal reflux disease, right above the knee amputation, pressure ulcers, and deep vein

For Resident #6, the physician and Responsible Party have been notified regarding the omitted initials for Novolog insulin on 6/2/16, 6/18/16, 6/28/16, 7/22/16, 7/25/16, 7/2/16, 7/18/16, and 7/29/16. The physician and the RP have also been notified regarding the medication variance on 7/10/16 as well as the omitted accuchecks on 6/2/16, 6/18/16, and 7/14/16.

For Resident #8, the physician and the Responsible Party have been notified regarding the omitted initials for Novolog sliding scale on 6/5/16, 6/7/16, 6/14/16, 6/15/16, 6/16/16, 6/17/16, 6/20/16, 6/21/16, 6/22/16, 6/23/16, 6/27/16, 6/28/16, 6/29/16, 6/30/16, 7/6/16, 7/9/16, 7/15/16, 7/18/16 7/26/16, 7/28/16, 7/29/16, 8/8/16, and 8/9/16. The physician and responsible party have also been notified regarding omitted initials for Lantus Solostar insulin on 6/12/16, 6/14/16, 6/22/2016, 6/27/16, 7/15/16, 7/18/16, 7/23/16, 8/8/16, 8/9/16, 8/10/16, and 8/22/16.

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thrombosis.

The current admission Minimum Data set (MDS) with a reference date of 5/31/16 assessed the resident with a cognitive score of "10" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers, dressing, toileting, bathing, and hygiene.

The clinical record was reviewed. The physician ordered accuchecks before meals and at bedtime and to administer Novolog insulin 3 units for blood sugar(BS) 200-299, 6 units for BS 300-399, 9 units for BS 400-499 and to call the physician for BS less than 50 or greater than 500.

The comprehensive care plan was reviewed. The care plan contained a problem listed the resident was at risk for metabolic complications related to diabetes with interventions listed to administer medications as ordered and notify the physician as indicated.

The medication administration record (MAR) for August 2016 was reviewed. The nurse documented on the back of the MAR on 8/18 at 5:00 p.m. , "Novolog 8 units sq held-res BS 88". There was no notation in the nursing notes and no physician orders the physician had been informed of the nurse deciding to hold the insulin. A nurse also documented on 8/21/16 at 11:30 a.m. the Novolog had been held for a BS of 41 with a note to recheck. Again there was no documentation the physician had been informed and no recheck of the BS done.

The July 2016 MAR was reviewed. The nurse documented a BS at 11:30 a.m. on 7/8 of 503 and

The physician and the RP were also notified of omitted initials for accu-checks on 6/12/16, 6/14/16, 6/22/16, 6/27/16, 7/2/16, 7/6/16, 7/15/16, 7/28/16, and 7/29/16.

2. For residents currently residing in the center with physician's orders for insulin and accu-checks, the DCS/Designee has conducted a review of the Medication Administration Record for the previous thirty (30) days to identify further concerns regarding administration of insulin and completion of accu-checks per the physician's 1 order. The review also included verification of physician notification of blood glucose parameters per the physician order. The physician and the responsible party will be notified as indicated by the reviews.

3. Education has been provided by the DCS/Designee regarding following physician's orders for administering and documenting insulin, and completing and documenting accu-

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a BS of 500 at 9:00 p.m. There was no evidence the nurse notified the physician as ordered. The nurse documented administration of 9 units of Novolog insulin at 11:30 a.m. The amount documented at 9:00 p.m. was illegible.

The nurse failed to administer Levemir insulin 20 units as ordered by the physician every 12 hours at 9:00 p.m. on 7/26.

The MAR for June 2016 also was reviewed. The failed to administer Levemir 18 units at 9:00 p.m. on 6/6, 6/10, 6/11, 6/17, and 6/20.

The director of nursing (DON) provided the survey team with copies of the facility policy on "Insulin Administration". The policy stated the "clinical nurse was to administer insulin subcutaneously per the physician order".

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m. There was no further information provided by the facility prior to exit.

3. For Resident #6 the facility staff failed accurately monitor BS (blood sugar) levels and failed to accurately administer insulin per the physician's orders.

Resident #6 was admitted to the facility on 05/25/12 and readmitted on 09/01/15. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, peripheral vascular disease, diabetes mellitus, hyperlipidemia, dementia, dysphagia, hypothyroidism and psychotic disorder.

The most recent comprehensive MDS with and ARD (assessment reference date) of 02/20/16

checks. The education also included notification to the physician as ordered regarding blood glucose readings and following physician orders to hold insulin as well as documentation of such physician notification.

A review will be conducted for three (3) residents per week for three (3) months to ensure that insulin has been administered per the physician's order, accu-checks have been completed with physician notification of the blood glucose results per the physician's order, and these have been documented.

4. The results of the review will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.

5. 10/4/2016

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coded the Resident as 3 of 15 in Section C, cognitive patterns. This is significant change MDS.

Resident #6's clinical record was reviewed on 08/23/16. It contained a signed POS (physician's order summary) dated 08/01/16 which read in part "Novolog Flex Pen Pref Syr (prefilled syringe) sliding scale 0-200= 0 u (units) 201-250=2u 251-300= 4u 301-350= 6u 351-400=8u 401-450=10u 451-500=12u >500=12u", "Novolog mix 70-30 units/1ml vial-inject 27 units subcutaneously every day-DM (diabetes mellitus)", "Novolog Mix 70-30 units/1ml vial -inject 8 units subcutaneously every day-DM", and "Accuchecks twice daily".

Resident #6's MAR's (medication administration record) for the months of June and July 2016 were reviewed. The MAR's contained an entry which read in part "Novolog Flex Pen Pref Syr (prefilled syringe) sliding scale 0-200= 0 u (units) 201-250=2u 251-300= 4u 301-350= 6u 351-400=8u 401-450=10u 451-500=12u >500=12u". This entry had not been signed as having been completed on 07/22 at 5pm and 07/25 at 5pm. On 07/10/16 the Resident's BS was recorded as 251 at 8am and the amount of insulin administered was recorded as 2u. The MAR's contained an entry which read in part "Novolog mix 70-30 units/1ml vial-inject 27 units subcutaneously every day-DM (diabetes mellitus)". This entry had not been signed as having been administered on 06/02, 06/18, 07/02 or 07/18. The MAR's contained an entry which read in part "Novolog Mix 70-30 units/1ml vial -inject 8 units subcutaneously every day-DM". This entry had not been signed as having been administered on 06/28 or 07/29. The MAR's

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contained an entry which read in part "Accuchecks twice daily". This entry had not been signed as having been completed on 06/02 at 8am or 5pm, 06/18 at 8am, and 07/14 at 5pm.

The concern of the missing documentation of the insulin administration and accuchecks was brought to the attention of the administrative staff during a meeting on 08/23/16 at approximately 1630. The RNC (regional nurse consultant) stated that they could not confirm that the medications/treatments had been completed as ordered.

No further information was provided prior to exit.

4. For Resident #8 the facility staff failed to accurately monitor BS (blood sugar) levels and accurately administer insulin per the physician's orders.

Resident #8 was admitted to the facility on 02/22/15 and readmitted on 03/14/16. Diagnoses included but not limited to atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, aphasia, cerebrovascular accident, dementia, respiratory failure, and dysphagia.

The most recent MDS (minimum data set) with and ARD (assessment reference date) of 08/02/16 coded the Resident as 0 of 15 in section C, cognitive patterns. This is an annual MDS.

Resident #8's clinical record was reviewed on 08/23/16. It contained a signed POS (physician's order summary) dated 08/01/16 which read in part "Novolog Flex Pen Pref Syr (prefilled syringe)

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100unit/1ml insulin pen-inject subcutaneously per sliding scale as follows: 200-250=2u, 251-300=4u, 301--350=6u, 351-400=8u, 401-450=10u, 451-500=12u-call MD if <50 or >500 for DM (diabetes mellitus)", "accuchecks before meals and a bedtime for DM", and "Lantus Solostar 100uni/1ml insulin pen-inject 20 units subcutaneously at bedtime for DM". Resident #8's MAR (medication administration record) for June 2016 contained an entry which read in part "Novolog Flex Pen Pref Syr (prefilled syringe) 100unit/1ml insulin pen-inject subcutaneously per sliding scale as follows: 200-250=2u, 251-300=4u, 301--350=6u, 351-400=8u, 401-450=10u, 451-500=12u-call MD if <50 or >500 for DM (diabetes mellitus)". This entry had not been signed as having been administered on 06/16-17, 06/20, 06/23, or 06/28-30 at 11:30am, 06/05, or 06/29 at 4:30pm, and 06/07, 06/14-15, 06/17, 06/21-22, 06/27 or 06/29 for 9pm. The MAR contained an entry which read in part "accuchecks before meals and at bedtime for DM". This entry had not been signed as having been completed on 06/12, 06/14, 06/22 or 06/27 at 9p and no BS (blood sugar) had been recorded on 06/20 at 11:30am or 06/13 at 4:30pm. The MAR contained an entry which read in part "Lantus Solostar 100uni/1ml insulin pen-inject 20 units subcutaneously at bedtime for DM". This entry had not been signed as having been administered on 06/12, 06/14, 06/22, or 06/27.

The MAR for July contained an entry which read in part "Novolog Flex Pen Pref Syr (prefilled syringe) 100unit/1ml insulin pen-inject subcutaneously per sliding scale as follows: 200-250=2u, 251-300=4u, 301--350=6u, 351-400=8u, 401-450=10u, 451-500=12u-call MD if <50 or >500 for DM (diabetes mellitus)". This

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entry had not been signed as having been administered on 0728-29 at 6:30am, 07/26 at 11:30am, 07/09, 07/15, or 07/26 at 4:30, and 07/06, 07/09, 07/15, 07/18, or 07/26 at 9pm. The MAR contained an entry which read in part "accuchecks before meals and at bedtime for DM". This entry had not been signed as completed on 07/29 at 6:30am, 07/06 or 07/15 at 9pm and no BS had been recorded for 07/28 at 6:30am or07/02 at 11:30am. The MAR contained an entry which read in part "Lantus Solostar 100uni/1ml insulin pen-inject 20 units subcutaneously at bedtime for DM". This entry had not been signed as having been administered on 07/15, 07/18, or 07/23.

The MAR for August contained an entry which read in part "Novolog Flex Pen Pref Syr (prefilled syringe) 100unit/1ml insulin pen-inject subcutaneously per sliding scale as follows: 200-250=2u, 251-300=4u, 301--350=6u, 351-400=8u, 401-450=10u, 451-500=12u-call MD if <50 or >500 for DM (diabetes mellitus)". This entry had not been signed as having been administered on 08/08 at 9pm or 08/09 at 11:30am. The MAR contained an entry which read in part "Lantus Solostar 100unit/1ml insulin pen-inject 20 units subcutaneously at bedtime for DM". This entry had not been signed as having been administered on 08/08-10 or 08/22.

The Resident's clinical record contained telephone order dated 08/23/16 which read in part "Hold Novolog sliding scale until insulin is received from pharmacy. The time of the order was 1740. Surveyor spoke with the RNC (regional nurse consultant) on 08/24/16 at approximately 0915 regarding the Novolog insulin. RNC stated that the insulin had arrived from the pharmacy,

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but no one could confirm when/if insulin had been administered.

The concern of the missing documentation of the insulin administration and accuchecks was brought to the attention of the administrative staff during a meeting on 08/23/16 at approximately 1630. The RNC (regional nurse consultant) stated that they could not confirm that the medications/treatments had been completed as ordered.

No further information was provided prior to exit.

F 333

F 369 SS=D 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS

The facility must provide special eating equipment and utensils for residents who need them.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to provide the correct feeding utensils for 1 of 20 Residents, Resident #20.

The findings included.

The Residents CCP (comprehensive care plan) indicated the Resident was to use plastic silverware at meals. The Resident was observed by the surveyor to be using regular utensils.

The record review revealed that Resident #20 was admitted to the facility 09/07/09. Diagnoses included, but were not limited to, dementia, dysphagia, atrial fibrillation, anemia, and

F 369

1. **Resident #20 was provided with plastic silverware during the survey process.**
2. **Residents currently residing in the facility requiring alternative silverware/eating utensils have the potential to be affected. A review has been conducted by the DCS/Designee for current residents residing in the facility requiring alternative silverware/eating utensils to ensure that required silverware/eating utensils are provided as indicated.**
3. **Education has been provided to the employees in the dietary department by the ED/Designee regarding provision of alternative silverware/eating utensils as indicated during mealtime.**

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F 369	Continued From page 73 No further information regarding this issue was provided to the survey team prior to the exit conference.	F 369		
F 387 SS=D	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 and clinical record review, the facility staff failed to ensure timely physician visits for 1 of 20 residents. (Resident #10) The findings included: Resident #10 was admitted to the facility on 10/28/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, stroke, dementia, anxiety and depression. On the resident ' s MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 6 out of 15. Resident #10 requires set up help only for dressing and bathing. During the clinical record review on 8/23/16, it was noted by the surveyor that there were 2	F 387	**1. Resident #10 currently has been seen by the physician and visits are timely.** **2. Current residents residing in the facility have the potential to be affected. A review has been conducted by the DCS/Designee regarding physician's visits.** **3. Education has been provided to the physician(s) regarding timeliness of visits. A review will be conducted by the DCS/Designee weekly for three (3) residents to ensure that physician visits are conducted on a timely basis.** **4. The results of the reviews will be discussed by the DCS/Designee\ at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.** **5. 10/4/2016**	

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F 387	Continued From page 74 progress notes that could not be found in the clinical record. There was a progress note dated for 3/28/16 and another one for 8/8/16. On 8/23/16 at 4:30 pm, the administrative team was notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference.	F 387		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review the facility staff	F 425	**1. For Resident #5, the physician and responsible party have been notified that Fentanyl was unavailable on 8/1/16.** **For Resident #20, the physician and the responsible party have been notified that mirtazapine was unavailable on 8/2/16.** **For Resident #2, the physician and the responsible party have been notified that Norco was unavailable on 8/15/16 and 8/16/16.** **For Resident #13, the physician and the responsible party have been notified that Fentanyl was unavailable on 8/18/16 and 8/19/16.** **For Resident #15, the physician and the responsible party have been notified that Valium was unavailable on 7/19/16.** **For Resident #1, the physician and the responsible party have been notified that Doxepin was unavailable on 8/8/2016.**	

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failed to ensure physician ordered medications were available for administration for 6 of 20 Residents, Residents #5, #20, #2, #1, #13, and #15.

The findings included.

1. For Resident #5, the facility failed to ensure the physician ordered medication fentanyl was available for administration.

The record review revealed that Resident #5 had been readmitted to the facility on 07/15/16. Diagnoses included, but were not limited to, sepsis, osteoarthritis, morbid obesity, heart failure, and chronic obstructive pulmonary disease.

Section C (cognitive status) of the Resident's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/22/16 included a BIMS (brief interview for mental status) score of 12 out of 15 points. Indicating the Resident was cognitively intact.

The Residents clinical record included a physician signed (08/_/16) POS (physician order sheet) that included an order for the pain medication fentanyl duragesic patch apply 1 patch topically every 72 hours.

When reviewing the Residents MAR's (medication administration records) it was noted that the facility nursing staff had documented that on 08/01/16 at 9:00 a.m. the Residents fentanyl patch was not available for administration. The Resident did have scheduled oxycodone ordered every 6 hours and a prn (as needed) order for oxycodone for pain.

F 425

2. For current residents residing in the center, a review has been conducted of the physicians orders and the Medication Administration Record for the previous thirty (30) days by the DCS/Designee to identify medication availability concerns. The physician and the responsible party have been notified as indicated by the results of the review.

3. Education has been provided by the DCS/Designee to the Licensed Nurses regarding the process for acquiring medications and ensuring that medications are available as ordered by the physician. The DCS/Designee will conduct a weekly review for three (3) residents per week for three (3) months to ensure that medications are available for administration as ordered by the physician.

4. The results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.

5. 10/4/2016

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During a meeting with the survey team on 08/24/16 at approximately 3:20 p.m. the administrative staff were notified that Resident #5's fentanyl patch was not available for administration on 08/01/16.

The facility policy/procedure titled "Medication Shortages/Unavailable Medications." read in part "...Upon discovery that Facility has as inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy..."

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #20, the facility failed to ensure the physician ordered medication mirtazapine was available for administration.

The record review revealed that Resident #20 was admitted to the facility 09/07/09. Diagnoses included, but were not limited to, dementia, dysphagia, atrial fibrillation, anemia, and hypertension.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/11/16 included a BIMS (brief interview for mental status) score of 2 out of a possible 15 points.

Resident #20 had a physician order for mirtazapine 7.5 mg by mouth at bedtime for depression/appetite stimulation.

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When reviewing the Residents MAR's (medication administration records) it was noted that the facility nursing staff had documented on 08/02/16 at 9:00 p.m. that the medication was not available for administration and would be delivered.

The surveyor did not find any documentation that this medication had been delivered to the facility and administered to the Resident on 08/02/16.

The administrative team was notified of the above during a meeting with the surveyors on 08/25/16.

The facility policy/procedure titled "Medication Shortages/Unavailable Medications." read in part "...Upon discovery that Facility has as inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy..."

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. The facility staff failed to ensure the pain medication, Hydrocodone-Acetaminophen (Norco) 7.5/325 mg, was available for administration for Resident #2.

Resident #2 was admitted to the facility on 8/17/15 with diagnoses of diabetes, end stage renal disease, aphasia, Guillian -Barre syndrome, hypertension, insomnia, depression, coronary artery disease, stroke, urinary tract infection, peptic ulcer disease, and chronic osteomyelitis.

The current quarterly Minimum Data Set (MDS) with a reference date of 5/30/16 assessed the

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resident with a cognitive score of "11" of "15". The resident was able to communicate with with gestures. The resident was assessed requiring total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, hygiene, and bathing. The resident was assessed to have bowel and bladder incontinence.

The clinical record was reviewed. The physician ordered Norco 7.5-325 mg 1 tablet given via gastrostomy tube every 4 hours with a start date of 7/13/16.

The August 2016 medication administration record was reviewed. The record contained evidence the nurse had circled initials noting the Norco had not been given at 8:00 p.m. on 8/15. The nurse documented on the back of the MAR waiting for pharmacy arrival. The nurse documented at 4:00 p.m. on 8/15/16 and 8/16/16 the Norco was "not available pharmacy called".

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m. There was no further information provided by the facility prior to exit.

4. The facility staff failed to ensure the physician ordered medication fentanyl was available for administration.

Resident #13 was originally admitted to the facility on 6/29/11 and then readmitted on 6/18/14 with the following diagnoses of, but not limited to anemia, high blood pressure, heart failure, Alzheimer ' s disease and dementia. Resident #12 was coded in the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/15/16 as having a BIMS (Brief Interview for

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Mental Status) score of 1 out of a possible score of 15.

During the clinical record review, the surveyor noted on Resident #13 ' s MAR (Medication Administration Record) for the month of August, 2016 that it contained documentation that the fentanyl patch was not available from pharmacy on 8/18/16 and 8/19/16. There was no documentation in the clinical record that the resident had been experiencing pain nor where there any behavior problems during this time.

The regional nurse was notified of the above documented findings on 8/25/16. The regional nurse stated, " There is a plan in place for this, someone just dropped the ball. "

The facility policy titled " Medication Shortages/Unavailable Medications " read in part " ...Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy ... "

The administrative team was notified of the above documented findings on 8/25/16.

No further information was provided to the surveyor prior to the exit conference.

5. The facility staff failed to ensure that the physician ordered medication Valium was available to administer to Resident #15.

Resident #15 was admitted to the facility on 3/2/15 with the following diagnoses of, but not limited to anemia, Multiple Sclerosis, malnutrition,

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anxiety, dysphagia and gastrostomy. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/10/16 as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #15 is totally dependent on 2 staff members for dressing, personal hygiene and bathing.

During the clinical review of Resident #15 ' s chart, the surveyor noted on the back of a July, 2016 MAR (Medication Administration Record) , that on " 7/19/16 at 12 mn (midnight) Valium was on the way from RX (pharmacy). The resident receives Valium by peg tube every 6 hours. There was no documentation found that would support what time the medication did arrive from the pharmacy.

The regional nurse was notified of the above documented findings on 8/25/16. The regional nurse stated, " There is a plan in place for this, someone just dropped the ball. "

The facility policy titled " Medication Shortages/Unavailable Medications " read in part " ...Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy ... "

The administrative team was notified of the above documented findings on 8/25/16.

No further information was provided to the surveyor prior to the exit conference.

6. The facility staff failed to ensure the physician

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ordered medication Doxepin was available to be administrated to Resident #1.

Resident #1 was originally admitted to the facility on 7/20/16. The resident was readmitted back into the facility on 7/8/16 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, peripheral vascular disease, neurogenic bladder, wound infection, quadriplegia, depression, bilateral above the knee amputation and pressure ulcer of the sacral region.

The resident was coded on the MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 6/27/16 with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was also coded as being totally dependent on 1 staff member for eating, dressing and personal hygiene.

The clinical record as well as the resident ' s MAR (Medication Administration Record) for the month of August 2016 was reviewed by the surveyor.

On the back of the August MAR, the following was documented " 8/8/16 9 pm Doxepin 10 mg (milligram) po (by mouth) not available. "

The regional nurse was notified of the above documented findings on 8/25/16. The regional nurse stated, " There is a plan in place for this, someone just dropped the ball. "

The facility policy titled " Medication Shortages/Unavailable Medications " read in part " ...Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately

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IEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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F 425 Continued From page 82

initiate action to obtain the medication from Pharmacy ... "

The administrative team was notified of the above documented findings on 8/25/16.

No further information was provided to the surveyor prior to the exit conference.

F 431 483.60(b), (d), (e) DRUG RECORDS, SS=D 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 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

F 425

F 431

1. **The bottle of metoclopramide was removed from the counter on Unit 1 during the survey process by LPN #3. The card of omeprazole and the card of lisinopril were also removed from the top of the medication cart on the 400 hall of Unit 1 during the survey process by LPN #3. There were no residents adversely affected.**
2. **Facility rounds/observations have been conducted by the DCS/Designee to ensure that no further medications were left unattended or out of view.**
3. **Education has been provided to the Licensed Nurses by the DCS/Designee regarding ensuring that medications are not left unattended or out of view and that medications remain secured. The DCS/Designee will conduct weekly observations on each unit for three (3) months to ensure that medications are secured and not left unattended or left out of the Licensed Nurses' view.**

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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, and staff interview, the facility staff failed to ensure medications were properly stored on 1 of 2 units, unit I.

The findings included.

The facility nursing staff left the medications metoclopramide, omeprazole, and lisinopril unattended and out of view.

On 08/25/16 at approximately 6:10 a.m. the surveyor observed a 16 ounce bottle of metoclopramide (reglan) unattended on top of the counter at the unit I nurses station. There were six female Residents in their wheelchairs sitting at this same nursing station.

The surveyor sat down at the nurse's station and when turning around the surveyor noted the medication was no longer on top of the counter.

Upon approaching the medication cart on the 400 hall (unit I) the surveyor was able to observe two cards of medication turned upside down on top of the cart. The surveyor flipped the cards over one card contained thirty tabs of omeprazole and the other card contained thirty tabs of lisinopril. The surveyor was able to observe one female Resident in the vicinity sitting in her wheelchair. The nursing staff on this hall was in a Residents

4. The results of the observations will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan to sustain substantial compliance.

5. 10/4/2016

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F 431	Continued From page 84 room. When LPN (licensed practical nurse) #3 returned to the medication cart the surveyor asked them if they had removed the bottle of metoclopramide from the top of the nursing station to which they replied they had. When asked about the medication on top of the cart LPN #3 verbalized to the surveyor that the medications were in the wrong cart and they had removed them to put in the other cart. LPN #3 acknowledged that the medication should not have been left out of the medication cart. The surveyor requested from the facility their policy/procedure on medication storage. This policy/procedure read in part "...Facility should ensure that all medications and biologicals...are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors... " The administrative staff were notified of the improperly stored medications during a meeting with the survey team on 08/25/16. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 431		
F 441 SS=E	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.	F 441	**1. Ice scoop holders have been placed on the outside of the ice chest so that the ice scoop can be stored appropriately in between filling resident water**	

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(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 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, facility documents review and clinical record review, the facility staff failed to follow standard infection control guidelines on 1 of 2 units (unit II) and failed to follow infection control policies and procedures for 3 of 20 Residents, Residents #1,

pitchers. Gloves are no longer worn during distribution of ice on ice pass.
For Resident #1, education \ has been provided to LPN #1 regarding maintaining appropriate infection control practices during treatment administration including changing gloves and washing hands when transitioning from dirty to clean surfaces.

There were no negative effects to Resident #1.
For Resident #15, the tubing was \ changed and the tube feeding was reconnected to the resident \ during the survey process. There were no negative effects to Resident #15.
For Resident #8, education has been provided to RN #1 regarding maintaining appropriate infection control practices during treatment administration including changing gloves and washing hands when transitioning from dirty to clean surfaces as well as sanitizing scissors appropriately during treatment administration. There were no negative effects to Resident #8.

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F 441	Continued From page 86 #15, and #8.	F 441		

The findings included.

1. The facility staff filled the water pitchers on unit II with ice in a manner that could increase the risk for the ice to be contaminated.

On 08/24/16 at approximately 6:40 a.m. the surveyor observed CNA (certified nursing assistant) #1 pass ice to the Residents on unit II. CNA #1 was observed by the surveyor to enter the Residents room obtain the Residents water pitcher bring it out into the hallway and fill the ice pitcher with ice from an ice chest. After filling up the ice pitcher the CNA would return the ice pitcher to the Residents room.

After the CNA left the ice chest and returned to the Residents room the surveyor opened the ice chest and observed the ice scoop laying over in the ice and water. The handle of the ice scoop was observed to be touching the ice and water.

When CNA #1 returned to the ice chest the surveyor interviewed them regarding their procedure of passing ice/water. When asked about the ice scoop CNA #1 stated to the surveyor "It's nasty." I have complained about it several times we should have something on the side to put the ice scoop in. CNA #1 stated she tried to put the ice scoop in the ice with the handle facing up.

CNA #1 was observed by the surveyor to wear gloves. However, CNA #1 was observed entering several Resident rooms and was not observed to change her gloves, wash her hands, or perform any hand hygiene between Residents and/or

2. Residents currently residing in the facility requiring treatment administration have the potential to be affected. The DCS/Designee has conducted random treatment observations on Unit 1 and Unit 2 to ensure that Licensed Nurses follow appropriate infection control practices during treatment administration including appropriate donning/changing of gloves, handwashing when transitioning between soiled and clean surfaces, and sanitizing scissors prior to, during, and after treatment administration as appropriate. Facility rounds/observations have also been conducted by the DCS/Designee to ensure that there were no further infection control concerns during distribution of i

3. Education has been provided by the DCS/Designee to the Licensed Nurses regarding maintaining appropriate infection control practices including donning /changing gloves, handwashing when transitioning between soiled and clean surfaces, and sanitizing scissors prior to, during, and after treatment administration as appropriate. Education has also been

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Resident rooms.

The administrative staff were notified of the infection control issue regarding the ice scoop in a meeting with the survey team on 08/24/16 at approximately 3:20 p.m.

The facility policy/procedure titled "Standard Precautions" read in part "...Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and before going to another resident. IMMEDIATELY wash hands after removing gloves..."

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. The facility staff failed to follow infection control policy during a wound care dressing change on Resident #1.

Resident #1 was originally admitted to the facility on 7/20/16. The resident was readmitted back into the facility on 7/8/16 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, peripheral vascular disease, neurogenic bladder, wound infection, quadriplegia, depression, bilateral above the knee amputation and pressure ulcer of the sacral region.

The resident was coded on the MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 6/27/16 with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was also coded as being totally dependent on 1 staff member for eating, dressing and personal hygiene.

provided to the nursing staff regarding maintaining appropriate infection control practices during ice distribution including storing the ice scoop separately from the ice and sanitizing hands appropriately between residents when distributing ice.

The DCS/Designee will conduct observations for three (3) Licensed Nurses completing treatment administration/dressing changes weekly for three (3) months to ensure that appropriate infection control practices are followed including appropriate donning/changing of gloves, handwashing when transitioning between soiled and clean surfaces, and sanitizing scissors prior to, during, and after treatment administration as appropriate.

Facility rounds/observations will be conducted by the DCS/Designee three (3) times per week for three (3) months during facility ice distribution/ice pass to ensure that appropriate infection control practices are being followed including storing the ice scoop separately from

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The surveyor observed Licensed Practical Nurse (LPN) #1 perform wound care on Resident #1. The surveyor made the following observation:

- LPN #1 put on a pair of gloves and removed old dressing then discarded gloves appropriately.
- LPN #1 went into bathroom and washed her hands.
- LPN #1 then placed another pair of gloves on and cleaned the wound bed with gauze soaked in saline.
- LPN #1 proceeded to take the new dressing supplies out of the packaging and applied it to the wound on the resident ' s sacral wound.
- She then removed her gloves and washed her hands.

After LPN #1 had left the room, the surveyor asked LPN #1 if she could remember anything that she would have done differently during the wound care. LPN #1 stated, " I don ' t believe so. You have made me so nervous. " When the surveyor explained to LPN #1 that she had gloves on that had been used to clean the wound bed, LPN #1 stated, " I should had changed my gloves between going from dirty to clean. "

The regional nurse and unit manager #1 were notified of the above documented observations that the surveyor had made during wound care on 8/24/16. The regional nurse stated, " Yes, they are to wash their hands after they clean the wound and put on new gloves to apply the new dressing to the area. "

On 8/24/16 at 4:30 pm, the administrative team was notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference.

the ice and handwashing/hygiene appropriately between residents during ice distribution.

4. **The results of the observations will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.**
5. **10/4/2016**

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3. The facility staff failed to follow infection control in regards to the tube feeding for Resident #15.

Resident #15 was admitted to the facility on 3/2/15 with the following diagnoses of, but not limited to anemia, Multiple Sclerosis, malnutrition, anxiety, dysphagia and gastrostomy. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/10/16 as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #15 is totally dependent on 2 staff members for dressing, personal hygiene and bathing.

On initial tour of the facility on 8/22/16 at approximately 6:20 pm, the surveyor went into Resident #15 ' s room. The surveyor observed the feeding tubing was draped over the IV pole but was not connected to the resident. The tip end of the feeding tube was not covered. The Surveyor asked the resident how long has it been that the feeding tube had not been restarted. Resident #15 stated, " Ever since I took my bath at 2 pm this afternoon. I have told different ones but it hasn ' t got done. "

At 7:30 pm, the surveyor went back into the resident ' s room to observe if the feeding tube had been restarted. The surveyor noted the feeding tube in the same location as documented above, with the end of the feeding tube uncovered.

At 8:30 pm, the surveyor once again, went into the resident ' s room and observed the feeding tube in the same manner in which it had been on

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the first 2 observations.

On 8/23/16 at approximately 8 am, the surveyor went into the resident ' s room. The resident was asleep but the feeding tube was infusing by IV pump.

The regional nurse and director of nursing were asked to give this surveyor a copy of the policy and procedure concerning feeding tubes and how they are to be stored if not in use.

The administrative team was notified of the above documented findings at the end of the day conference on 8/23/16.

On 8/24/16, the director of nursing stated to the surveyor, " We cannot find a policy regarding what you were asking for. But if it had been me, I would have covered the tip of the tube so that any infections could not get in there. "

No further information was provided to the surveyor prior to the exit conference.

4. For Resident #8 the facility staff failed to follow established infection control procedures during a dressing change by placing gloved hand in pocket to remove scissors and taking scissors into bathroom.

Resident #8 was admitted to the facility on 02/22/15 and readmitted on 03/14/16. Diagnoses included but not limited to atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, aphasia, cerebrovascular accident, dementia, respiratory failure, and dysphagia.

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The most recent MDS (minimum data set) with and ARD (assessment reference date) of 08/02/16 coded the Resident as 0 of 15 in section C, cognitive patterns. Section M, skin conditions coded the Resident as being at risk for developing pressure ulcers, having unhealed pressure ulcers, having two stage 3 pressure ulcers not present on admission. This is an annual MDS.

The surveyor observed dressing change being completed on Resident #8's stage III heel/ankle decubitus ulcers by RN (registered nurse) #1 on 08/23/16 at approximately 0755. RN #1 washed hands, and then donned clean gloves. RN #1 then reached into pocket of scrub top, removed scissors and used them to remove old dressing from Resident's left foot, without cleaning them. RN #1 placed soiled dressing and gloves into trash receptacle. RN# 1 washed hands, donned fresh gloves, and cleaned the wound. RN #1 removed soiled gloves, washed hands and donned fresh gloves. RN #1 applied treatment to wound, applied bandage to wound, then applied Kling dressing to wound, using same scissors to cut dressing. RN #1 removed gloves and washed hands. RN #1 donned fresh gloves and using scissors, removed old dressing from Resident's right foot. RN #1 placed soiled dressing and gloves into trash receptacle. RN #1 washed hands, taking scissors into bathroom with her. RN #1 donned fresh gloves, placed scissors on barrier, cleaned wound, removed soiled gloves and washed hands. RN #1 donned clean gloves, applied treatment to Resident's R ankle, applied bandage, and applied Kling dressing, using scissors to cut. RN #1 removed soiled gloves, placed in trash receptacle, tied and removed

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trash bag, then washed hands.

Surveyor discussed wound care observation with RNC (regional nurse consultant) on 08/23/16 at approximately 0830. RNC stated that RN #1 should not have placed hand in pocket to retrieve scissors after gloving, nor should have taken scissors into bathroom.

The concern of the breech in infection control was discussed with the administrative staff during a meeting on 08/23/16 at approximately 1530.

No further information was provided prior to exit

F 456 SS=E 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews, the facility staff failed to ensure a proper working call bell system for 2 of 2 units.

The findings included:

Upon initial tour of the facility on 8/22/16 at 6 pm, there were 3 surveyors that were checking on the call bell system lights and did they work properly.

At 8:15 pm, two surveyors stood at the nurses ' station on Unit 1 and 1 surveyor went into a randomly picked room and activated the call bell system. The 2 surveyors at the nurses ' station

F 441

F 456

1. Residents residing in the facility were placed on increased supervision. The maintenance director conducted facility rounds/observations of call bells for residents currently residing in the facility to ensure that the light outside the residents' rooms' were functional. The call bell system has been repaired.

2. Residents residing in the facility were placed on increased supervision. The maintenance director conducted facility rounds/observations of call bells for residents currently residing in the facility to ensure that the light outside the residents' rooms' were functional. The call bell system has been repaired.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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could hear the call bell system alarming but the box at the nurses ' station that has buttons with room numbers on them did not work.

On 8/23/16 at 8 am, the surveyor was sitting on Unit 1 at the nurses ' station and observed the call bell system alarming but the room numbers on the box in the nurses ' station would randomly light up. At the nurses ' station, there were 3 ceiling lights that the surveyor observed being turned on when the call bell system was alarming on the 400 hallway showing which direction the call bell alarm was coming from. All three hallways had the lights in the ceiling at the beginning of the hallways but only the one for the 400 hallway worked.

The surveyor asked unit manager #1 if the call bell system had been working properly. Unit Manager #1 started, " They were here 2 weeks ago but I haven ' t seen a change in it. " The surveyor requested that the maintenance director be paged to come to unit 1 to discuss the call bell system.

At 8:15 am, the director of nursing was at the nurses ' station and the call bell system alarmed. Once again, the light in the ceiling for the 400 hallway came on and the light beside the resident ' s door came on but the box in the nurses ' station did not light up to show the room number that the call bell was ringing from. The surveyor asked the DON how the call bell was suppose to work. The DON stated, " I ' ll have to go and get the maintenance director to help you out with that. "

At 8:25 am, the regional nurse came back to the nurses ' station and asked if there was a problem

F 456

3. **Education has been provided to current employees regarding responding to call bells and monitoring for lights outside the resident rooms. The education also included maintaining increased supervision via increased frequency of rounds to identify potential resident needs. The ED/Designee will conduct random rounds on both units totaling ten (10) residents per week for three (3) months to monitor call bell function.**
4. **The results of the observations will be discussed by the ED/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.**
5. **10/4/2016**

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(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 456	Continued From page 94 with the call bell system. The surveyor notified the regional nurse of the above documented findings. At 8:30 am, the maintenance director came to the unit 1 nurses ' station and the surveyor asked him how the call bell system worked. The maintenance director stated, " I don ' t know how it works. " The surveyor asked if periodic maintenance was performed on the call bell system. The maintenance director stated, " I don ' t. They will let me know when a bulb burns out but that ' s about all. " The regional nurse brought to the surveyor a copy of an email for the approval of a new call bell system for the entire facility. The regional nurse also stated, " We have put everyone on 15 minute round checks until the new system has been installed. We have also educated all the staff on this procedure. " On 8/23/16 at approximately 6 pm, 2 surveyors were on unit 2 observing the call bell system. The same issues that occurred on unit 1 occurred on Unit 2. On 8/23/16 at 4:30 pm, the administrative team was notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference.	F 456		
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest	F 490	**1. The facility currently has a permanent Administrator/Executive Director employed effective 9/19/2016. The facility also has a DCS employed and the amount of agency staff utilized has been reduced.** **2. The facility currently has a permanent Administrator/Executive Director employed effective 9/19/2016.**	

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F 490	Continued From page 95 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on survey results it was determined the facility administration failed to use its' resources and nursing staff to ensure the residents in the facility were able to maintain or attain their highest practicable physical and/or emotional well-being. The facility had two adminstrators since the last survey, both no longer employed at the facility. The current acting administrator was from the corporate office. The director of nursing had resigned and the current acting director of nursing was the coporate nurse consultant. The facility used agency staffing for nursing and certified nursing assistants. The agency staff interviewed during the survey stated they were "agency" and did not have any information to offer the survey team. Residents, families, and a group of interviewable residents complained to the survey team that care was not being provided to the residents in regards to administration of medications, bathing, turning and repositioning, and cleanliness in the facility. Families voiced concerns the former administrators told them they were more concerned with marketing to new residents. For additional information regarding the administrative failure and the effect on facility residents, please see F-252, F309, F312, F314, F315, F328, F333, and F387.	F 490	**The facility also has a DCS employed and the amount of agency staff utilized has been reduced.** 3. **Education has been conducted by the Regional Director of Clinical Services /Designee regarding the regulation /requirement that a facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The RDCS/Designee will Assurance Performance Improvement Committee meeting process monthly for three (3) months to ensure that areas identified out of compliance are reviewed. The ED/Designee will also implement a Family Council Meeting quarterly for twelve (12) months to identify further performance improvement opportunities.** 4. **The ED/Designee will review areas identified as out of compliance as well as the plan of correction for these areas at the facility Quality Assurance Performance Improvement Committee Meeting monthly for three (3) months. The committee will recommend revision to the plan as indicated to sustain substantial compliance.** 5. **10/4/2016**	

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F 502 SS=D	483.75(j)(1) ADMINISTRATION	F 502		

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to obtain a physician ordered lab for 1 of 20 Residents, Resident #5.

The findings included.

The facility staff failed to obtain the physician ordered lab albumin.

The clinical record review revealed that Resident #5 had been readmitted to the facility on 07/15/16. Diagnoses included, but were not limited to, sepsis, osteoarthritis, morbid obesity, heart failure, and chronic obstructive pulmonary disease.

Section C (cognitive status) of the Resident's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/22/16 included a BIMS (brief interview for mental status) score of 12 out of 15 points. Indicating the Resident was cognitively intact.

The clinical record review revealed that Resident #5's physician had ordered an albumin and prealbumin lab test on 08/04/16.

Further review of the clinical record revealed that the facility staff had obtained the prealbumin on 08/05/16. The clinical record did not include any

1. For Resident #5, the physician and responsible party have been notified regarding the albumin level.
2. Residents currently residing in the facility with physician's orders for labs have the potential to be affected. A review has been conducted by the DCS/Designee for the previous thirty (30) days for residents with physician's orders for labs to ensure that labs have been obtained per the physician's order.
3. Education has been provided by the DCS/Designee to the Licensed Nurses regarding obtaining labs as ordered by the physician. The DCS/Designee will conduct a review for three (3) residents per week for three (3) months to ensure that labs have been obtained per the physician's order.
4. The results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
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F 502	Continued From page 97 results for the albumin lab. The unit manager was asked about the missing lab but was unable to locate the results. The administrative staff were notified that the facility staff failed to obtain a physician ordered lab for Resident #5 prior to the exit conference on 08/25/16. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 502		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based upon staff interview and clinical record review, the facility staff failed to report abnormal laboratory results to the physician for 1 of 20 residents in the survey sample. (Resident #1) The findings included: Resident #1 was originally admitted to the facility on 7/20/16. The resident was readmitted back into the facility on 7/8/16 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, peripheral vascular disease, neurogenic bladder, wound infection, quadriplegia, depression, bilateral above the knee amputation and pressure ulcer of the sacral region.	F 505	**F 505:** **1. For Resident #1, the physician and the responsible party have been notified of the results of the Basic Metabolic Panel from 7/1/2016.** **2. Residents residing in the facility with physician's orders for labs have the potential to be affected. A review has been conducted by the DCS/Designee for labs obtained within the previous thirty (30) days to ensure that the physician has been notified regarding lab results.**	

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The resident was coded on the MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 6/27/16 with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was also coded as being totally dependent on 1 staff member for eating, dressing and personal hygiene.

During the clinical record review of Resident #1 ' s clinical record, it was noted that on 7/1/16, a Basic Metabolic Panel was obtained from the resident and the blood was sent to a laboratory to obtain results. The following lab results were noted to be abnormal per laboratory reference ranges for Resident #1 on 7/1/16:
" Glucose H (high) 110Reference Range for this test was 70-99 mg/dl (milligram per deciliter) ...Sodium was L (low) Reference Range for this test was 135-145 and Creatinine L (low) 0.48 Reference Range for this test was 0.5-1.4 mg/dl.

On 8/24/16, unit manager #1 was notified of the above documented findings. " Let me look into this and I will get back to you.

At 3:55 pm, unit manager #1 returned to the surveyor and stated, " These were not called to the physician. I cannot find any documentation that states these were communicated. "

At 4:30 pm, the administrative team was notified of the above documented findings.

F 514 483.75(l)(1) RES
SS=E RECORDS-COMPLETE/ACCURATE/ACCESSIB LE

The facility must maintain clinical records on each

3. Education has been provided by the DCS/Designee to Licensed Nurses regarding ensuring that the physician is notified of lab results. The DCS/Designee will review to ensure that the physician has been notified of lab results for three (3) residents per week for three (3) months.

4. The results of the review will

be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.

5. 10/4/16

F 514

TRANSACTION REPORT

SEP/26/2016/MON 02:00 PM

'AX(TX)

#	DATE	START T.	RECEIVER	COM.TIME	PAGE	TYPE/NOTE	FILE
001	SEP/26	01:57PM	18008749625	0:02:11	4	MEMORY OK ECM	5695

PHYSICIAN'S ORDERS

mnicare of Lynchburg 434-845-5290 PHEASANT RIDGE

MEDICATIONS	HOUR
DNR	
MVI & Minerals PO qd - supplement	9AM
Mag Ox 400mg PO qd - supplement	9AM
ASA 81mg chew tab PO qd - AFib	9AM
Synthroid 150mcg PO qd - hypothyroidism	6AM
Protonix 40mg PO qd - GERD	630AM
Claritin 10mg PO qd - Allergies	9AM
Neurontin 100mg PO qAM - Polyneuropathy	9AM
DiHiazem 120mg PO qd - AFib	9AM

RESIDENT NAME Virginia Ridgeway DOB 10/2/27

SEND ALL MEDS (X) CHART ONLY (___)

DATE OF ADMISSION: 9/26/16

REHAB POTENTIAL: GOOD____ FAIR____ POOR____ MAINTENANCE____

OPT/OPTH PRN: YES X NO____

DENTIST PRN: YES X NO____

PODIATRY PRN: YES X NO____

MAY OPEN OR CRUSH MEDS: YES X NO____

CODE STATUS: DNR ADVANCE DIRECTIVES____

ACTIVITY LEVEL: as tolerated

THERAPEUTIC PASS ONLY____ MAY NOT GO LOA/PASS____ MAY GO LOA/PASS ATTENDED WITH MEDICATIONS____

*** MAY USE GENERIC EQUIVALENTS UNLESS OTHERWISE NOTED ***

*** THERAPY EVALUATIONS & TREATMENTS AS INDICATED ***

OCCUPATIONAL THERAPY: YES X NO____

SPEECH THERAPY: YES X NO____

PHYSICAL THERAPY: YES X NO____

*** DIETARY ORDERS ***

T.O. Dr. Ward/SS Claire RN 9/26/16

These orders are in effect for one year unless otherwise designated or limited by law.

MEDS REVIEWED BY: DATE:

PHYSICIANS SIGNATURE: DATE:

CHARTING FOR 9/26/16 THROUGH 9/30/16

Telephone No. Medical Record No.

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EASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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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 Resident interview, staff interview, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 9 of 20 Residents, Residents #5, #16, #1, #10, #13, #15, #6, #4, and #9.

The findings included.

1. For Resident #5, the facility staff documented in the Residents clinical record that the Resident was being treated for clostridium difficile when in fact they were not.

The clinical record review revealed that Resident #5 had been readmitted to the facility on 07/15/16. Diagnoses included, but were not limited to, sepsis, osteoarthritis, morbid obesity, heart failure, and chronic obstructive pulmonary disease.

Section C (cognitive status) of the Resident's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/22/16 included a BIMS (brief interview for

1. For Resident #5, an entry was made by the DCS/Designee clarifying the resident's status regarding clostridium difficile.
For Resident #16, the resident's baths are currently being documented.
For Resident #1, the resident's weights are currently being documented.
For Resident #10, a) the resident's weights are currently being documented b) a clarification order has been entered into the medical record clarifying the dates in which therapy was provided for Resident #10.
For Resident #13, the physician and the responsible party have been notified regarding the omitted initials on 8/14/2016 for the Mighty Shake.
For Resident #15, the weights are currently being documented in the medical record.
For Resident #6, the (2) lab reports for other residents residing in the facility were removed from the medical record.
For Resident #4, vital signs

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mental status) score of 12 out of 15 points. Indicating the Resident was cognitively intact.

On 08/18/16 the nursing staff documented in the Residents clinical record that Resident #5 continued antibiotic for c-diff (clostridium difficile) with no adverse reactions.

When interviewing the unit manager about the nursing entry on 08/18/16 regarding the c-diff. The unit manager verbalized to the surveyor that the Resident did not have c-diff and the nurse had charted in error.

The surveyor was unable to locate any further information in the clinical record regarding the c-diff.

The administrative staff were notified of the inaccurate record during a meeting with the survey team on 08/24/16 at approximately 3:20 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #16, the facility staff failed to document that they had provided ADL (activities of daily living) care in regards to bathing.

The clinical record review revealed that Resident #16 was admitted to the facility 07/25/16. Diagnoses included, but were not limited to, acute kidney failure, cellulitis lower limb, anxiety, lymphedema, and heart failure.

Section C (cognitive patterns) of the Residents initial MDS (minimum data set) assessment with

have been obtained and documented in the resident's medical record. Weights are currently documented in the medical record also. For Resident #9, vital signs have been obtained and are documented in the medical record. Weights are currently documented in the medical record also.

2. Residents currently residing in the facility have the potential to be affected. The following reviews have been conducted by the DCS/Designee:

a) A review has been conducted by the DCS/Designee for the previous thirty (30) days to ensure that residents currently residing in the center do not have inappropriate notations regarding clostridium difficile in their medical record.

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an ARD (assessment reference date) of 08/01/16 included a BIMS (brief interview for mental status) score of 15 out of a possible 15 points indicating the Resident was cognitively intact.

The record review revealed that the facility staff had documented that Resident #16 had received partial baths on August 2, 4, 5, 8, 10, 18, 19, 20, 21, and 23. Bed baths were documented on August 3 and 22.

During an interview with Resident #16 on 08/25/16 at approximately 10:20 a.m. the Resident verbalized to the surveyor that she received her shower/baths and was due to get one today.

The administrative staff were notified of the incomplete documentation regarding bathing on 08/25/16 prior to the exit conference.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. For Resident #1, the facility staff failed to document weights in the clinical record.

Resident #1 was originally admitted to the facility on 7/20/16. The resident was readmitted back into the facility on 7/8/16 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, peripheral vascular disease, neurogenic bladder, wound infection, quadriplegia, depression, bilateral above the knee amputation and pressure ulcer of the sacral region.

The resident was coded on the MDS (Minimum Data Set) with and ARD (Assessment Reference

F 514

b) A review has been conducted by the DCS/Designee for the previous thirty (30) days to ensure that baths have been documented.

c) A review has been conducted by the DCS/Designee for the previous thirty (30) days to ensure that Vital Signs and Weights have been documented in the medical record.

d) A review has been conducted by the DCS/Designee for the previous thirty (30) days to ensure that therapy orders are accurate on the Physician's Order Sheet (POS) regarding therapy services and therapy notes are present on the medical record.

e) A review has been conducted by the DCS/Designee for the previous thirty (30) days of the Medication Administration

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Date) of 6/27/16 with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was also coded as being totally dependent on 1 staff member for eating, dressing and personal hygiene.

During the clinical record review conducted by the surveyor, it was noted that no weights were documented in the clinical record.

On 8/24/16 at approximately 1:30 pm, the surveyor asked the interim director of nursing where the weights on the residents could be found in the clinical record. The interim DON stated, " They aren ' t. We just had to look for someone else and we found them in the director of nursing ' s office.

A copy of Resident #1 ' s weights was given to the surveyor.

The administrative team was notified of the above documented findings on 8/24/16.

No further information was provided to the surveyor prior to the exit conference.

4a. The facility staff failed to maintain a complete and accurate medical record for Resident #10.

Resident #10 was admitted to the facility on 10/28/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, stroke, dementia, anxiety and depression. On the resident ' s MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 6 out of 15. Resident #10 requires set up help

Record to identify further omitted medications including but not limited to Mighty Shakes. The physician and the responsible party will be notified as indicated by the findings of the review.

f) A review of the medical record has been completed by the DCS/Designee for current residents residing in the facility for the previous thirty (30) days to identify medical records that may contain information for other residents including but not limited to lab reports.

3. Education has been provided as follows:

a) Education has been provided by the DCS/Designee to the Licensed Nurses regarding ensuring that notations in the resident's medical record are accurate regarding medical conditions including clostridium difficile.

b) Education has been provided by the DCS/Designee to nursing staff regarding ensuring that baths that are given are documented as given.

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514	Continued From page 103 only for dressing and bathing. A clinical record review was conducted by the surveyor on 8/23/16. It was noted by the surveyor that there were no weights documented in the clinical record. The interim director of nursing was asked where weights should be kept in the medical record. The interim DON stated, " There should be a form that they fill out for weights. " This form could not be found in the clinical record by the surveyor or interim DON. A copy of Resident #1 ' s weights was given to the surveyor. The interim DON stated that they found the weights in the director of nurses ' office. The administrative team was notified of the above documented findings on 8/24/16. No further information was provided to the surveyor prior to the exit conference. 4b. The facility staff failed to maintain a complete and accurate clinical record for Resident #10. Resident #10 was admitted to the facility on 10/28/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, stroke, dementia, anxiety and depression. On the resident ' s MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 6 out of 15. Resident #10 requires set up help only for dressing and bathing. During the chart review by the surveyor, it was	F 514	**c) Education has been provided by the DCS/Designee to the Licensed Nurses regarding ensuring that vital signs and \ weights are documented in the medical record.** **d) Education has been provided by the DCS/Designee to the Licensed Nurses and the \ Therapy Department regarding ensuring that current orders for therapy services are accurate on the Physician's Order Sheet (POS) as well as ensuring that there are therapy notes present on the medical record for therapy services provided.** **e) Education has been provided by the DCS/Designee to the Licensed Nurses regarding ensuring that medications are administered as ordered by the physician, and that medications administered are documented as administered on the Medication Administration Record i.e. Mighty Shakes.**	

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	495325	A. BUILDING _____ B. WING _____	C 08/24/2016

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noted that on the August 2016 Plan of Care, the physician had ordered the following to be performed: " PT (Physical Therapy) 5 x (times)/ week x 30 days ...OT (Occupational Therapy) 5 x /week x 30 days ... "

At 9 am, the physical therapist #1 came and spoke to the surveyor concerning Resident #10 receiving therapy services. The surveyor also verbalized to physical therapist #1 that there were no notes in the chart.

At 10:30 am, the physical therapist #1 came back to the surveyor and gave a copy of the an order to discontinue PT and PT services on 11/18/15 but " nursing never took that off of the plan of care. The resident never received services past this date. "

On 8/24/16 at 4:30 pm, the administrative team was notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference.

5. The facility staff failed to maintain a complete and accurate clinical record for Resident #13.

Resident #13 was originally admitted to the facility on 6/29/11 and then readmitted on 6/18/14 with the following diagnoses of, but not limited to anemia, high blood pressure, heart failure, Alzheimer ' s disease and dementia. Resident #12 was coded in the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/15/16 as having a BIMS (Brief Interview for Mental Status) score of 1 out of a possible score of 15.

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f) Education has been provided by the DCS/Designee to the Licensed Nurses as well as the Medical Records Coordinator regarding ensuring that information present on the medical record is accurate and they there is not information for multiple residents filed in resident medical records.

A review will be completed by the DCS/ Designee for three (3) residents per week for three months and will include the following areas:

a) There is not inappropriate notation regarding Clostridium Difficile in the residents' medical record.

b) Baths have been completed and documented in the medical record.

c) Vital Signs and weights have been obtained and are documented in the medical record.

d) Current physician's orders including the Physician's Order Sheet are accurate regarding therapy services and there are current therapy notes on the medical record for therapy services being provided.

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NTERS FOR MEDICARE & MEDICAID SERVICES

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Clinical record reviews was conducted by the surveyor and it was noted on the August, 2016 MAR (Medication Administration Record) that on 8/14/16 at 9 am and again at 1 pm there was no documentation of medication being given. The boxes were left blank and nothing was documented on the back of the MAR to state why the medicine was not given. The medication that was to be administered was Mighty Shakes by mouth three times a day as ordered by the physician.

6. The facility staff failed to maintain a complete and accurate clinical record for Resident #15.

Resident #15 was admitted to the facility on 3/2/15 with the following diagnoses of, but not limited to anemia, Multiple Sclerosis, malnutrition, anxiety, dysphagia and gastrostomy. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/10/16 as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #15 is totally dependent on 2 staff members for dressing, personal hygiene and bathing.

A clinical record review was conducted by the surveyor on 8/25/16. It was noted by the surveyor that there were no weights documented in the clinical record.

The interim director of nursing was asked where weights should be kept in the medical record. The interim DON stated, " There should be a form that they fill out for weights. " This form could not be found in the clinical record by the surveyor or interim DON.

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e) Medications including Mighty Shakes are being administered as ordered by the physician and are documented on the medical record.

f) There is only information for the correct resident filed on each resident's medical record and there is no other resident's information misfiled i.e. lab reports.

4. The results of the reviews

will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.

5. 10/4/2016

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A copy of Resident #15 ' s weights was given to the surveyor. The interim DON stated that they found the weights in the director of nurses ' office.

The administrative team was notified of the above documented findings on 8/25/16.

No further information was provided to the surveyor prior to the exit conference.

7. For Resident #6, the facility staff failed to ensure an accurate clinical record.

Resident #6 was admitted to the facility on 05/25/12 and readmitted on 09/01/15. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, peripheral vascular disease, diabetes mellitus, hyperlipidemia, dementia, dysphagia, hypothyroidism and psychotic disorder.
The most recent comprehensive MDS with and ARD (assessment reference date) of 02/20/16 coded the Resident as 3 of 15 in Section C, cognitive patterns.

Resident #6's clinical record was reviewed on 08/23/16. It contained two laboratory reports for two different Residents of the facility.

The surveyor spoke with the medical records person on 08/23/16 at approximately 0855 regarding the misfiled reports and she stated "I don't know why those are in there, they shouldn't be filed anywhere because they haven't been signed by the physician". She then took the reports and placed them in a folder for the physician to sign.

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The concern of the misfiled reports was brought to the attention of the administrative staff during a meeting on 08/23/16 at approximately 1630.

No further information was provided prior to exit.

8. The facility staff failed to ensure a complete and accurate clinical record for Resident #4.

Resident #4 was admitted to the facility on 2/18/15 and re-admitted on 5/24/16 with diagnoses of diabetes, paraplegia, urinary retention, malnutrition, chronic pulmonary embolism, hypertension, psychosis, anemia, gastro esophageal reflux disease, right above the knee amputation, pressure ulcers, and deep vein thrombosis.

The current admission Minimum Data set (MDS) with a reference date of 5/31/16 assessed the resident with a cognitive score of "10" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers, dressing, toileting, bathing, and hygiene.

The clinical record was reviewed. The record did not contain vital signs or weights recorded for Resident #4.

The unit manager (RN#2) was asked on 8/23/16 at 9:00 a.m. for the current weights for Resident #4. RN#2 stated the clinical record should contain a form for recording of vital signs and weights. Resident #4's clinical record did not contain the form. The director of nursing was able to find 3 weights obtained for Resident #4 on the 24 hour reports.

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The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/24/16 at 1:30 p.m. There was no further information provided by the facility prior to exit.

9. The facility staff failed to ensure complete and accurate clinical record for Resident #9.

Resident #9 was admitted to the facility on 4/12/13 with diagnoses of dementia, anxiety, depression, pseudobulbar affect, arthritis, dysphagia, and anemia

The current quarterly Minimum Data Set (MDS) with a reference date of 7/26/16 assessed the resident with a cognitive score of "0" of "15". The resident was assessed requiring extensive assistance of 1 person for bed mobility, transfers, dressing, eating, toileting, bathing , and hygiene.

The clinical record was reviewed. The record did not contain recorded vital signs or weights. The resident was receiving supplements of Magic Cup, Mighty shakes, and med pass twice daily for weight loss. No weights were recorded in the clinical record since 4/26/16. The resident had the nursing measure to weigh monthly.

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/24/16 at 1:30 p.m. There was no further information provided by the facility prior to exit.