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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7-26-16 through 7-28-16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements for Nursing Facilities. Three complaints were investigated during the survey. The census in this 180 dually certified bed facility was 153 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and 6 closed record reviews (Residents #22 through #27).	F 000	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. Date of Compliance: 8/17/2016	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278	F 278 1) Residents #2 and #21 are properly coded for bathing. Resident #2 is accurately coded under Range of Motion. 2) All residents are at risk. 3) Education for all MDS nurses will be completed by Regional Data Analysis/Verification Specialist or designee related to: a. Creating assessment notes and speaking with staff when there are discrepancies in documentation b. Coding Range of Motion accurately. 4) DON or designee will audit 100% of MDS assessments completed in past 30 days for accuracy in coding related to: Bathing and Range of Motion. Then quarterly during following QA meeting. 5) Date of Compliance: 8/17/2016	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/15/16

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

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penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure the Minimum Data Set (MDS) assessment accurately reflects the resident's status for two residents (Residents # 21 and # 2) in a survey sample of 27 residents.

1. For Resident # 21, the facility staff failed to code bathing accurately on the 5/31/2016 Quarterly MDS (minimum data set) assessment.

2. For Resident #2, the facility staff failed to code bathing on the 12-16-15 full admission MDS accurately, and failed to code range of motion accurately on the 6-13-16 quarterly MDS (minimum data set) assessment.

Findings included:

1. For Resident # 21, the facility staff failed to code bathing accurately on the 5/31/2016 Quarterly MDS (minimum data set) assessment.

Resident # 21 was admitted to the facility originally on 2/25/2016 with the diagnoses of, but not limited to, Hypertension, Dementia, Gastroesophageal Reflux Disease, and Malignant Neoplasm of the Brain Stem.

The most recent Minimum Data Set (MDS) was a

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quarterly assessment with an Assessment Reference Date (ARD) of 5/31/2016. The MDS coded Resident # 21 with a BIMS (Brief Interview for Mental Status) of 6/15 indicating severe cognitive impairment. Resident # 21 was coded as requiring supervision with set up help only with (ADL) activities of daily living except limited assistance of one staff person with bed mobility, transfer and toilet use. Resident # 21 was also coded as always continent of bowel and occasionally incontinent bladder. There were dashes entered under "bathing".

Review of the clinical record was conducted on 7/27/2016 at 4:45 PM.

On 7/28/2016 at 9:10 AM, an interview was conducted with RN (Registered Nurse) A, MDS Coordinator who stated that dashes appear in the Section G Bathing when the MDS staff enter the codes indicating the activity did not occur. RN A stated the MDS staff coded it that way because staff did not observe the activity. RN A stated she would talk with the other MDS staff member to see if any other information was available.

On 7/28/2016 at 9:40 AM, an interview was conducted with the other MDS staff member (RN E) who stated the facility staff told MDS staff that Resident # 21 usually bathed herself and was dressed before day shift staff arrived each day. RN E stated the MDS staff reviewed the documentation for bathing and noted there was no data noted in the system. RN E showed the surveyor what the document looked like when MDS staff queried the system for documentation during the look back period. Review of the document entitled "MDS Response Import, Intervention/Task: Item 1 ADL-Bathing" revealed

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"no data found". RN E stated that information prompted the MDS staff to talk with the direct care staff. RN E stated the direct care staff on day shift told them Resident # 21 "was bathed and dressed by herself every day when they arrived; she was already groomed." RN E stated Resident # 21 bathed and dressed herself during the night shift just before day shift arrived.

Review of the care plan revealed documentation of Focus area: The Resident has an ADL self-care performance deficit and under interventions was listed. the need to " Provide bathing/dressing/grooming supplies such as brush, comb, soap, water. Instruct and reinforce use of these supplies. Cue resident to bathe/dress/groom self."

Review of the CNA ADL documentation sheets for the look back period showed set up only for Personal Hygiene and Dressing but nothing documented under Bathing.

On 7/28/2016 at 10:50 AM, an interview was conducted with CNA (Certified Nursing Assistant) A who stated she often worked with Resident # 21. CNA A stated Resident # 21 was dressed when day shift staff came to work. CNA A stated the 11-7 shift helped the resident with bathing by supervising. CNA A showed the surveyor the method the staff use to document ADLs on the tracking system and stated that there was a code for "supervision" for bathing. CNA A stated the night shift could have documented the bathing activity since it occurred on that shift

During the end of day debriefing on 7/28/2016, the facility administrator, Director of Nursing (DON) and Corporate Consultant Nurse were

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informed of the findings. The Corporate Consultant Nurse stated she was unsure of how the staff should have coded the bathing activity when they did not see it occur. When the surveyor asked if any staff member saw bathing activity occur, the DON stated the night shift assisted the resident. The DON stated the direct care staff should have documented the bathing activity on the tracking system and the MDS staff should not put dashes on the MDS assessments.

No further information was provided.

2. For Resident #2, the facility staff failed to code bathing on the 12-16-15 full admission MDS accurately, and failed to code range of motion accurately on the 6-13-16 quarterly MDS (minimum data set) assessment.

Resident #2 was admitted to the facility on 12-9-15. Diagnoses included, fall with fracture to the left ankle, anemia, hemiplegia, hypertension, vitamin D deficiency, and cervical diskectomy.

Resident #2's admission MDS with an ARD (assessment reference date) of 12-16-15 was coded with a BIMS (brief interview of mental status) of 15 out of 15 possible points, indicating no cognitive impairment. Under the activities of daily living (ADL) functional status section "G0110" bathing, facility staff coded that the activity did not occur for the entire 7 day look back. The Resident required extensive assistance of one staff member for all ADL's except eating.

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An interview was conducted with the MDS Coordinator on 7-27-16 at 2:00 p.m., and she stated that the information compiled in the MDS assessment was gathered from the Activity of Daily Living (ADL) sheets completed by the Certified Nursing Assistants (CNA's) daily. Those ADL sheets were requested and revealed only 2 entries in regard to bathing, those were for 12-10-16 and 12-14-16. Both documented the Resident did not bathe. She also stated that she had found out that the CNA's who documented no bath were documenting incorrectly, and were only counting showers or tub baths, and were not counting bed baths, which the Resident had received daily. She stated she had only recently uncovered this.

Resident #2's most recent quarterly MDS with an ARD (assessment reference date) of 6-13-16 was coded with a BIMS (brief interview of mental status) of 15 out of 15 possible points, indicating no cognitive impairment. Under functional Limitation in Range of Motion section "G0400", the facility staff coded that the Resident had no impairment in Range of motion for the entire 7 day look back.

On 7-27-16 at 9:20 a.m., Resident #2 was observed, and interviewed in bed. The resident was in an upright sitting position with no shirt on and wearing an adult incontinence brief, covered from the waist and including the lower extremities, with a sheet. His feet were exposed. The Resident was alert and oriented. During an interview with the resident, Resident #2 showed that he could only shrug his shoulders, and was not able to move or use his left hand, and elbow. His left hand was contracted inward toward his palm. He stated he was unable to use his left

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side because of a traumatic injury years ago to his spinal cord. His left foot was turned inward toward the midline, and showed the positioning of foot drop. He was unable to move it.

A review of the facility clinical record conducted 7-27-16, revealed an updated care plan dated 12-17-15. Included in the document was " The Resident has an ADL self care performance deficit R/T (related to) Hemiplegia, Limited Mobility." Provide sponge bath when a full bath or shower can not be tolerated." Created on 7-13-16. Also found in the care plan was, "Contractures, the Resident has contractures of bilateral feet. Provide skin care daily to keep clean and prevent skin breakdown". Created on 7-13-16.

Guidance is given in "Long-Term Care Facility Resident Assessment Instrument User's Manual MDS 3.0 May 2013, p. 249, The Definition of bathing is, " How the Resident takes a full bath, shower or sponge bath. Guidance also reveals that the person completing the MDS assessment should talk to staff and ascertain "how does the Resident get bathed", etc, which will give information on the types of ways a Resident may bathe. Also on page, 260 the definition of "Functional Limitation in Range of Movement" is "Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the Resident at risk of injury.

The items in these sections are intended to code Resident limitations that have a direct relationship to the resident's current functional status, medical treatments, nursing monitoring, and serves as a guide to needed care. One of the important

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F 278	Continued From page 7 functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status, and provide required assistance monitoring assessments to direct the care planning process. The MDS coordinator did not speak with staff regarding bathing for Resident #2 in December 2015, and in turn coded bathing incorrectly. Also, the Resident's impairments with Range of motion were well documented, however, were coded incorrectly in the most recent June 2016 MDS assessment. On 7-26-16 at 4:00 p.m. the administration was informed of the findings. No further information was provided.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed, for 2 residents, (Resident #11 and Resident #5) in the survey sample of 27 residents, to follow the professional standards of nursing for the documentation of medication administration. 1. For Resident #11, the facility staff failed to document the administration of thyroid (Synthroid on 4/9/16), and bowel management (Senexon on 4/22/16) medications.	F 281	F 281 1) Residents #5 and #11 are receiving medications as prescribed. Residents had no adverse effect from deficient practice. MD has been made aware. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate licensed staff on Documentation/Medication administration recording, per Policy and Procedure. 4) DON or designee will audit 100% of MARs 5 times weekly for 4 weeks, then quarterly during following QA meeting. 5) Date of Compliance: 8/17/2016	

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2. For Resident #5 the facility staff failed to ensure Omeprazole, Symbicort, Baclofen, Neurontin, Natural tears eye drops, and Ipratropium/Albuterol hand held nebulizer inhaled treatment medications were as administered on 7-5-16.

The Findings Included:

. Resident #11 was an 86 year old who was admitted to the facility on 2/21/14. Resident #11's diagnoses included Thyroid Disorder, Anxiety Disorder, Major Depressive Disorder, Dementia with Behavioral Disturbance and Schizophrenia.

The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 6/16/16, coded Resident #11 as having a Brief Interview of Mental Status Score of 9, indicating severe cognitive impairment.

On 7/27/16 a review was conducted of Resident #11's clinical record. The signed Physician Orders for May 2016 read, 1) "Senexon 8.6 MG. - 50 MG. (milligram) Tablet. Give 2 tablets orally at bedtime for bowel aid." 2) "Synthroid Tablet 150 MG. Give 1 tablet by mouth one time a day for thyroid disorder."

"The Medication Administration Record for May, 2016 did not have the following medications documented as having been administered on specific dates:

A) 4/7/16 at 9:00 P.M. - "Senexon 8.6 MG. - 50 MG. Tablet. Give 2 tablets orally at bedtime for bowel aid."

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B) 4/22/16 at 6:00 A.M. - "Synthroid Tablet 150 MG. Give 1 tablet by mouth one time a day for thyroid disorder."

Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, page 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

1. The right medication
2. The right dose
3. The right client
4. The right route
5. The right time
6. The right documentation."

On 7/27/16 a review was conducted of facility documentation. The General Dose Preparation and Medication Administration Policy Revised 1/13/13 read, "Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, PRN medications, if medications are refused) on appropriate forms." (PRN = as needed)

On 7/28/16 at 10:00 A.M. an interview was conducted in the conference room with the Director of Nursing (Administration B). When asked about the importance of documenting medication administration, he stated, "To make

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sure the patient gets the medication as ordered. We must document before going on to another resident."

On 7/28/16 at 4:30 P.M. the Administrator (Administration A) was informed of the findings. No further information was received.

2. For Resident #5, the facility staff failed to ensure Omeprazole, Symbicort, Baclofen, Neurontin, Natural tears eye drops, and Ipratropium/Albuterol (hand held nebulizer inhaled treatment) medications were administered on 7-5-16.

Resident #5 was admitted to the facility on 9-25-14. Diagnoses included; diabetes, paraplegia, major depression, hypertension, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease (GERD), polyneuropathy, asthma, cerebrovascular disease, and anxiety.

Resident #5's most recent Minimum Data set assessment was a quarterly assessment with an assessment reference date of 6-10-16. She was coded with a Brief Interview of Mental Status score of 14 indicating no cognitive impairment. Resident #5 required extensive to total assistance from one to two staff members, with all activities of daily living, with the exception of eating.

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Resident #5's clinical record was reviewed on 7-26-16 at 2:30 p.m., and revealed a Medication Administration Record (MAR) which had no documentation on 7-5-16 that the Resident had received Omeprazole at 6:00 a.m., Baclofen at 6:00 a.m., Symbicort Aerosol inhaled at 9:00 p.m., Bacofen at 9:00 p.m., Neurontin at 9:00 p.m., Ipratropium-Albuterol inhaled solution at 9:00 p.m., and Artificial tears eye solution at 9:00 p.m. Multiple other morning and evening medications were signed as administered on 7-5-16.

Review of the Physician's Orders revealed the omitted 6 current orders are below:

1 Omeprazole 20 mg (milligrams) in the morning at 6:00 a.m., for GERD
2. Baclofen 10 mg 3 times per day at 6:00 a.m., 5 00 p.m., and 9:00 p.m., for muscle spasm.
3. Symbicort Aerosol 160-4.5 mcg (micrograms) 2 inhalations every 12 hours at 9:00 a.m., and 9:00 p.m., for shortness of breath and CAD (Cardiac Artery Disease).
4. Neurontin 600 mg 3 times per day at 9:00 a.m., 2:00 p.m., and 9:00 p.m., for nerve pain.
5. Ipratropium-Albuterol solution 0.5-2.5 (3 mg/3 milliliters) inhale orally 4 times per day at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m., for shortness of breath.
6. Tears Naturalle II solution (Artificial tears) instill one drop 4 times per day at 9:00 a.m., 1:00 p.m., 5.00 p.m., and 9:00 p.m., age related nuclear bilateral cataracts and resulting dry eyes.

Nursing Progress Notes were reviewed, and revealed no notes had been documented for 7-5-16.

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F 281	Continued From page 12 The issue was reviewed with the Director of Nursing (DON) on 7-26-16 at 4:00 p.m., the DON had no explanation as to the omitted medications. The DON stated "Potter and Perry, and Lippincott" as their nursing reference for their standards of practice. Both sources give the same standards. Fundamentals of Nursing, 6th Edition, Potter-Perry, p. 419, provides the following guidance regarding physicians' orders, "Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients." The facility provided no further information.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed for one resident (Resident #24) in a sample of 27 residents, to obtain and initiate physician orders for wound care in a timely manner and failed to accurately describe the type of wound present	F 309	F 309 1) Residents #24 is no longer in the facility. 2) All residents with admitted wounds are at risk. 3) Staff Development Coordinator or designee will educate all licensed staff admitting residents on importance of initiating treatment orders on admission. 4) DON or designee will audit 100% of residents admitting with wounds for initiation of treatment on admitting day for 3 weeks, then quarterly during following QA meeting 5) Date of Compliance: 8/17/2016	

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F 309	Continued From page 13 and failed for one resident (Resident #5) to ensure medications were administered in a survey sample of 27 residents. 1. For Resident #24, the facility staff failed to obtain physician orders for a back wound upon admission and incorrectly described the wound as a pressure ulcer, when in fact, it was an abscess that was surgically treated prior to admission. 2. For Resident #5 the facility staff failed to ensure Omeprazole, Symbicort, Baclofen, Neurontin, Natural tears eye drops, and Ipratropium/Albuterol hand held nebulizer inhaled treatment medications were administered on 7-5-16. The findings included: 1. Resident #24 was admitted to the facility on 7/24/15 with the diagnoses of, but not limited to, status post I&D (incision and drainage) of a back abscess with MRSA (methicillin resistant staphylococcus aureus) requiring intravenous antibiotics, ESRD (end stage renal disease) with hemodialysis, congestive heart failure and diabetes mellitus type 2. Resident #24 was discharged to the hospital on 8/5/15 therefore a closed record review was conducted. The most recent Minimum Data Set (MDS) was an initial assessment with an Assessment Reference Date (ARD) of 7/30/15. The MDS coded Resident #24 with no cognitive impairment, required extensive assistance from staff for bed mobility, transfers, dressing, toilet use and	F 309	F 309 Continued 1) Resident #5 is receiving medications as prescribed. Resident had no adverse effect from deficient practice. MD has been made aware. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate all licensed staff on Medication Administration/ Documentation per policy and procedure. 4) DON or designee will audit 100% of MARs 5 times weekly for 4 weeks, then quarterly during following QA meeting. 5) Date of Compliance: 8/17/2016	

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personal hygiene.
Section M Skin Conditions M1040 "Other Ulcers, Wounds and Skin Problems" was coded at "D. Open lesion (s) other than ulcers, rashes, cuts (e.g., cancer lesion)." Resident #24 was not coded as having a pressure ulcer.

On 7/27/16 at 10:50 a.m., Resident #24's electronic clinical record was reviewed. The review revealed physician orders which included:

"Wound Care to back every day and evening shift for Wound Care Irrigate w/NS (normal saline), Fill wound w/ 1/4 strength Dakins Soluiton (sic) damp gauze..." The order was dated 7/25/15 and transcribed onto the treatment record on 7/25/15 at 1759 (5:59 p.m.); however the treatment was not initiated until 7/26/15 on the "day" shift which was two days after admission.

Further record review revealed the "Admission Assessment/Screening-Nursing" dated 7/24/15 described the back wound as a Stage 3 pressure ulcer of the sacrum. Subsequent "Wound Record" documentation recorded on 7/26/15 and 7/31/15 listed the back wound as a Stage 3 pressure ulcer of the midline back.

Resident #24's care plan created on 7/26/15 included, "The resident has abscess to midline back," with an intervention of "Administer treatments as ordered and monitor for effectiveness..."

The "History and Physical" performed by the physician listed the primary diagnosis as "Back Abscess S/P I&D (status post incision and drainage), CHF." Discharge hospital information dated 7/16/15 included "OPERATION

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PERFORMED: Incision, debridement and abscess drainage of the left lower back. Debridement included skin, subcutaneous tissue and fascia."

On 7/27/16 at 2:30 p.m. the Director of Nursing (Admin-B) was informed of the care plan and MDS listing the wound as an abscess but nurses notes described the wound as a pressure ulcer.

On 7/27/16 at 3:05 p.m. an interview was conducted with the MDS Registered Nurse (RN-A). RN-A stated, "This gentleman came in with a midline wound, the admission nurse documented it as a sacrum but it was not a pressure ulcer."

An end of day meeting was conducted on 7/27/16 at 4:10 p.m. with the Administrator, Director of Nursing and Corporate Nurse. They were informed of the conflicting documentation of Resident #24's wound and the delay in initiating treatment to the area.

Facility policy titled "General Wound Care/Dressing Changes" included: "PROCEDURE: 1. Notify the physician and obtain orders for treatment(s) and dressing changes..."

On 7/28/16 at 9:45 a.m. an interview was conducted with RN-A. When asked why she coded the area on the MDS as a non pressure ulcer, she stated "I went to the hospital notes and physician notes and with my own assessment I coded it the accurate way." When asked why she didn't document her assessment and discuss her findings with the Director of Nursing or nurses, she stated "We do that all the time."

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RN-A stated she unable to find any documentation of her wound assessments.

On 7/28/16 at 11:40 a.m. an interview was conducted with Admin-B. When asked why wound care orders were not obtained until the second day of admission, Admin-B stated he was "Looking into it for the timing." He stated "The resident was admitted later in the day then went to dialysis the next morning." At 11:50 a.m., Admin-B stated "I have nothing els."

No further information was provided by the facility staff.

Complaint Deficiency.

2. For Resident #5 the facility staff failed to ensure Omeprazole, Symbicort, Baclofen, Neurontin, Natural tears eye drops, and Ipratropium/Albuterol hand held nebulizer inhaled treatment medications were administered on 7-5-16.

Resident #5 was admitted to the facility on 9-25-14. Diagnoses included; diabetes, paraplegia, major depression, hypertension, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease (GERD), polyneuropathy, asthma, cerebrovascular disease, and anxiety.

Resident #5's most recent Minimum Data set assessment was a quarterly assessment with an assessment reference date of 6-10-16. She was coded with a Brief Interview of Mental Status score of 14 indicating no cognitive impairment. Resident #5 required extensive to total assistance

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from one to two staff members, with all activities of daily living, with the exception of eating.

Resident #5's clinical record was reviewed on 7-26-16 at 2:30 p.m., and revealed a Medication Administration Record (MAR) which had no documentation on 7-5-16 that the Resident had received Omeprazole at 6:00 a.m., Baclofen at 6:00 a.m., Symbicort Aerosol inhaled at 9:00 p.m., Bacofen at 9:00 p.m., Neurontin at 9:00 p.m., Ipratropium-Albuterol inhaled solution at 9:00 p.m., and Artificial tears eye solution at 9:00 p.m.. Multiple other morning and evening medications were signed as administered on 7-5-16.

Review of the Physician's Orders revealed the omitted 6 current orders as below;

1. Omeprazole 20 mg (milligrams) in the morning at 6:00 a.m., for GERD
2. Baclofen 10 mg 3 times per day at 6:00 a.m., 5:00 p.m., and 9:00 p.m., for muscle spasm.
3. Symbicort Aerosol 160-4.5 mcg (micrograms) 2 inhalations every 12 hours at 9:00 a.m., and 9:00 p.m., for shortness of breath and CAD (Cardiac Artery Disease).
4. Neurontin 600 mg 3 times per day at 9:00 a.m., 2:00 p.m., and 9:00 p.m., for nerve pain.
5. Ipratropium-Albuterol solution 0.5-2.5 (3 mg/3 milliliters) inhale orally 4 times per day at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m., for shortness of breath.
6. Tears Naturalle II solution (Artificial tears) instill one drop 4 times per day at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m., age related nuclear bilateral cataracts and resulting dry eyes.

Nursing Progress Notes were reviewed, and

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F 309	Continued From page 18 revealed no notes had been documented for 7-5-16. Review of the Resident ' s care plan revealed an intervention for " Give medications according to doctor ' s orders. " The issue was reviewed with the Director of Nursing (DON) on 7-26-16 at 4:00 p.m. The DON had no explanation as to the omitted medications. The DON stated "Potter and Perry, and Lippincott" as their nursing reference for their standards of practice. Both sources give the same standards. Fundamentals of Nursing, 6th Edition, Potter-Perry, p. 419, provides the following guidance regarding physicians' orders, "Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients." The facility provided no further information.	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration, or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329	F 329 1) Resident #18's order is corrected in the eMAR system and now being administered as ordered by MD. 2) All residents receiving blood pressure medications with perimeters are at risk. 3) Staff Development Coordinator or designee will educate all licensed staff on the importance of obtaining blood pressures per perimeter as ordered.	

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F 329	Continued From page 19 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record, and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure one Resident (Resident #18) in a survey sample of 27 Residents was free from unnecessary medication. For Resident #18, the facility staff failed to obtain a blood pressure prior to administering Bumetanide per physician's order. An order was evident for the medication to only be administered if Resident #18's systolic pressure was greater than 110 mmHg (millimeters of mercury). The findings included: Resident #18, a female, was admitted to the facility 12/11/15. Her diagnoses included lymphedema, muscle weakness, cellulitis, dysphagia, gastroesophageal reflux disease, type II diabetes mellitus, chronic obstructive pulmonary disease, urinary retention, congestive heart failure, hypertension, asthma, bipolar, major	F 329	F 329 Continued 4) DON or designee will audit 100% of residents receiving blood pressure medication with perimeters, for blood pressure taken prior to administration, then 10% for 3 weeks, then quarterly in following QA meeting. 5) Date of Compliance: 8/17/2016	

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depressive disorder, chronic pain, embolism, morbid obesity, anemia, hypothyroidism, anxiety, and chronic venous hypertension with ulcer.

Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/26/16 was coded as a quarterly assessment. Resident #18 was coded as having no memory deficits and was able to make her own daily life decisions. She was also coded as needing extensive assistance of one staff member to perform her activities of daily living, with the exception of eating. For eating, Resident #18 was coded as needing standby assistance only.

Resident #18 was observed during medication pour and pass observation. She was lying on her back with the head of her bed elevated. Resident #18 was oriented, alert, and verbally responsive. LPN (licensed practical nurse) B had reviewed her notes and Resident #18's blood pressure had been obtained and was 137/77 mmHg.

Review of Resident #18's clinical record revealed a signed physician's order, "Bumetanide 2 MG (milligram) Give 1 tablet by mouth two times a day for hypertension/edema. Hold for systolic BP (blood pressure) under 110." A corresponding entry was noted on the eMAR (electronic medication administration record).

Review of the eMAR revealed no evidence that Resident #18's blood pressure had been obtained prior to the administration of the medication. No evidence was available within the eMAR to indicate that Resident #18's blood pressure had been obtained twice daily prior to administration of Bumetanide.

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When interviewed 7/28/16 at 10:10 a.m., LPN B stated the blood pressures should be documented in the computer system under the vital signs area.

Review of the vital signs electronic record revealed Resident #18's blood pressure had not been obtained twice daily, generally was obtained once a day on day shift. While the medication was ordered to be administered at 9 a.m. and 2 p.m., the blood pressures that had been obtained were not prior to either of the administration times with the exception of 7/17/16 at 9:37 a.m. (only obtained once on 7/27/16), 7/19/16 at 9:26 a.m. (only once that day), and 7/27/16 at 9 a.m. and 1 p.m.

When interviewed, the DON (director of nursing) stated 7/28/16 at 9:47 a.m., the nurse that entered the order into the computer system should have entered for the blood pressure to be documented on the eMAR.

Review of the facility's policy entitled, "General Dose Preparation and Medication Administration" included:

"Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:

4.1 Facility staff should:

4.1.5 If necessary, obtain vital signs."

Guidance was provided at www.medline.gov:

"Bumetanide is a strong diuretic ('water pill') and

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F 329	Continued From page 22 may cause dehydration and electrolyte imbalance. It is important that you take it exactly as told by your doctor. If you experience any of the following symptoms, call your doctor immediately: rapid, excessive weight loss; decreased urination; dry mouth; thirst; nausea vomiting; weakness; drowsiness; confusion; muscle pain or cramps; or rapid or pounding heartbeats. Bumetanide comes as a tablet to take by mouth. It usually is taken once a day. When used to treat edema, a second or third dose may be given every 4 to 5 hours depending on the amount of swelling. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take bumetanide exactly as directed." The administrator, DON, and corporate consultant were informed of the failure of the staff to ensure Resident #18's blood pressure was obtained twice daily prior to administering Bumetanide per physician's orders, 7/28/16 at 11:58 a.m.	F 329		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section, write, sign, and date progress notes at each visit, and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.	F 386	F 386 1) Residents #7 and #10 Physician Order Summary Recertification are current and signed by MD. 2) All residents are at risk. 3) Educate all licensed staff on entering the Physician Order Summary Recertification order and ensuring the physician Is signing order every 60 days.	

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This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure the physician's orders were signed timely for two residents (Resident # 7 and Resident # 10) in a survey sample of 27 residents.

1. For Resident # 7, the facility staff failed to ensure that Physicians Order Sheets were signed timely between 1/29/2016 and 7/7/2016 resulting in 160 days between signatures .

2. For Resident # 10, the facility staff failed to ensure that Physicians Order Sheets were signed timely between 1/29/2016 and 7/7/2016 resulting in 160 days between signatures.

Findings included:

1. For Resident # 7, the facility staff failed to ensure that Physicians Order Summary sheets were signed timely between 1/29/2016 and 7/7/2016 resulting in 160 days between signatures.

Resident # 7 was admitted to the facility on 1/29/2015 with the diagnoses of, but not limited to, Hypertension, Heart Failure, Chronic Obstructive Pulmonary Disease, Gastroesophageal Reflux Disease, Dementia, Legal Blindness, Gout and Cataracts.

The most recent Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 7/13/2016. The MDS coded Resident # 7 with a BIMS (Brief Interview

4) DON or Designee will audit 100% of residents staying long term care for current signed Physician Order Summary Recertification order, then 10% of residents for 3 weeks, then quarterly in following QA meeting.
5) Date of Compliance: 8/17/2016

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for Mental Status) of 8/15 indicating moderate cognitive impairment; required limited to extensive assistance of one staff person with activities of daily living. Resident # 7 was coded as frequently incontinent of bowel and bladder.

On 7/27/2016 at 9 AM, a clinical record review was conducted. The record review included electronic and paper clinical records.

Review of the clinical record revealed Progress notes written on 6/7/2016, 4/12/2016, 2/9/2016 and 12/15/2015.

Review of the monthly Medication Regimen Reviews (MRR) were done by the Pharmacy in January 2016 - July 2016. The actual dates of MRR were 1/18/2016, 2/22/2016, 3/21/2016, 4/19/2016, and 5/21/2016, 6/21/2016 and 7/22/2016.

Review of the Physicians Order Summaries in the electronic medical record revealed the Physician Order Summary Reports were signed on 1/29/2016 and 7/7/2016. Calculation of time frame between signed Physicians Order Sheets from 1/29/2016 and 7/7/2016 resulting in 160 days between signatures.

Further review of the paper and electronic clinical record revealed no other the Physician Orders Sheets or Summaries in either clinical record.

An interview was conducted on 7/27/ 2016 at 4 PM with the Director of Nursing who stated he would review the record to see if any other Physician Orders summaries were signed. An interview was conducted with the Corporate Nurse Consultant who stated the facility had

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encountered a problem with the orders in the computer system where it would not automatically roll over to the next month. The Corporate Consultant stated the physicians should sign the Order Sheets timely and that the staff should ensure the orders were signed by the physician after each visit. The Corporate Consultant also stated there were no other signed Physician Order Sheets for Resident # 7.

During the end of day debriefing on 7/28/2016, the Administrator, Director of Nursing, and Corporate Consultant were informed of the findings Physicians Order Sheets not being signed timely. The Director of Nursing stated the expectation was that physicians would sign Physicians Order Sheets every 60 days.

No other information was provided.

2. For Resident #10, the facility staff failed to ensure that Physicians Order Sheets were signed timely between 1/29/2016 and 7/7/2016 resulting in 160 days between signatures.

Resident #10 was admitted to the facility on 6/8/2009 with the diagnoses of, but not limited to, Traumatic Brain Injury, Legal Blindness, Psychosis, Delusions and Major Depressive Disorder.

The most recent Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 5/12/2016. The MDS coded Resident #17 with moderate cognitive impairment; required extensive assistance of one staff person with activities of daily living except

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set up only for eating. Resident #17 was coded as frequently incontinent of bowel and always incontinent of bladder.

On 7/27/2016 at 2 PM, review of the clinical record was conducted. The record review included electronic and paper clinical records.

Review of the clinical record revealed Progress notes written on 6/5/2016, 4/11/2016, and 2/19/2016.

Review of the monthly Medication Regimen Reviews (MRR) were done by the Pharmacy in January 2016 - July 2016. The actual dates of MRR were 1/23/2016, 2/28/2016, 3/21/2016, 4/25/2016, and 5/23/2016, 6/20/2016 and 7/24/2016.

Review of the Physicians Order Summaries in the electronic medical record revealed the Physician Order Summary Reports were signed on 1/29/2016 and 7/7/2016. Calculation of time frame between signed Physicians Order Sheets from 1/29/2016 and 7/7/2016 resulting in 160 days between signatures.

Further review of the paper and electronic clinical record revealed no other the Physician Orders Sheets or Summaries in either clinical record.

An interview was conducted on 7/27/ 2016 at 4 PM with the Director of Nursing who stated he would review the record to see if any other Physician Orders summaries were signed. An interview was conducted with the Corporate Nurse Consultant who stated the facility had encountered a problem with the orders in the computer system where it would not automatically

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F 386	Continued From page 27 roll over to the next month. The Corporate Consultant stated the physicians should sign the Order Sheets timely and that the staff should ensure the orders were signed by the physician after each visit. The Corporate Consultant also stated there were no other signed Physician Order Sheets for Resident # 7. During the end of day debriefing on 7/28/2016 the Administrator, Director of Nursing, and Corporate Consultant were informed of the findings Physicians Order Sheets not being signed timely. The Director of Nursing stated the expectation was that physicians would sign Physicians Order Sheets every 60 days. No further information was provided.	F 386		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	F 441 1) Residents #18 and #17 have no adverse effects from the med pass on 7/27/2016. MD made aware of situation. 2) All residents are at risk. 3) Staff Development Coordinator or designee will educate all licensed staff related to appropriate infection control techniques including length of time to wash hands. 4) DON or designee will audit 5 med passes a week for 2 weeks, then 2 per week for 2 weeks, then quarterly in following QA meeting. 5) Date of Compliance: 8/17/2016	

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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 documentation review, and clinical record review, the infection control committee failed to ensure medications were administered in a manner to prevent the spread of infection for two Residents (Residents' #18 and #17) in a survey sample of 27 Residents.

1. For Resident #18, LPN (licensed practical nurse) B placed a contaminated paper medication cup on top of Resident #18's medications prior to administering the medications to Resident #18, and

2. For Resident #17, LPN A failed to wash her hands for appropriate time frame during medication preparation and administration.

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The findings included:

1. For Resident #18, LPN (licensed practical nurse) B placed a contaminated paper medication cup on top of Resident #18's medications prior to administering the medications to Resident #18.

Resident #18, a female, was admitted to the facility 12/11/15. Her diagnoses included lymphedema, muscle weakness, cellulitis, dysphagia, gastroesophageal reflux disease, type II diabetes mellitus, chronic obstructive pulmonary disease, urinary retention, congestive heart failure, hypertension, asthma, bipolar, major depressive disorder, chronic pain, embolism, morbid obesity, anemia, hypothyroidism, anxiety, and chronic venous hypertension with ulcer.

Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/26/16 was coded as a quarterly assessment. Resident #18 was coded as having no memory deficits and was able to make her own daily life decisions. She was also coded as needing extensive assistance of one staff member to perform her activities of daily living, with the exception of eating. For eating, Resident #18 was coded as needing standby assistance only.

Resident #18 was observed during medication pour and pass observation 7/27/16 at 8:52 a.m. She was lying on her back with the head of her bed elevated. Resident #18 was oriented, alert, and verbally responsive. LPN (licensed practical nurse) B prepared all of Resident #18's oral pill/tablet medications and put them in a plastic medication cup. After preparing the medications, LPN B put a paper medication cup on top of the

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medications in the plastic cup. The paper medication cup had been sitting on top of the medication cart, along with medication administration supplies. The medication cart keys, pens, LPN B's arms and hands, a bottle of hand sanitizer, cups, water pitcher, cups of applesauce, and other supplies were also on the top of the medication cart.

LPN B picked up the plastic medication cup with the medications, a cup of Constulose and Polyethylene glycol (both medications for constipation), and a cup of water and entered Resident #18's bedroom. Resident #18 refused the Constulose and Polyethylene Glycol. She took the rest of the medications, finishing at 9:06 a.m.

When interviewed regarding placing the paper medication cup on top of Resident #18's medications after it had been sitting on the top of the medication cart 7/27/16 at 10:10 a.m., LPN B stated she thought she had gotten a new cup from the stack of cups, not the cup that had been sitting on the cart.

The Infection control coordinator, RN (registered nurse) D was interviewed, 7/28/16 at 10:05 a.m. RN D stated "she shouldn't do that (place the paper cup on top of medications)..."

Guidance for infection control procedures during medication pour and pass www.cdc.gov <http://www.cdc.gov>
"Unused supplies and medications should be maintained in clean areas separate from used supplies and equipment (e.g., glucose meters). Do not carry supplies and medications in pockets."

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Guidance also was provided in "Fundamentals of Nursing 7th Edition, page 652, Use your critical thinking skills to prevent an infection from developing or spreading. Implement procedures to minimize the numbers and kinds of organisms that could be possibly transmitted. Eliminating reservoirs of infection, controlling portals of exit and entry, and avoiding actions that transmit microorganisms prevent bacteria from finding a new site to grow. Proper use of sterile supplies barrier precautions, standard precautions, transmission -based precautions and proper hand hygiene are examples of methods to control the spread of microorganisms."

Guidance is also provided, "Fundamentals of Nursing, 7th Edition, p. 713, For safe administration, use aseptic technique and proper procedures when handling and giving medication."

The administrator, DON (director of nursing), and corporate consultant were informed of the failure of LPN B to ensure a contaminated paper medication cup was not placed on top of Resident #18's medications prior to administration, 7/28/16 at 11:58 a.m.

2. For Resident #17, LPN A failed to wash her hands for appropriate time frame during medication preparation and administration.

Resident #17, a female, was admitted to the facility 2/5/16. Her diagnoses included unspecified dementia, dysphagia, muscle weakness, unspecified psychosis, hypertension, osteoarthritis, constipation, major depressive disorder, asthma, chronic obstructive pulmonary

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disease, and pain.

Resident #17's most recent MDS with an ARD of 6/9/16 was coded as a quarterly assessment. She was coded as having long and short term memory deficits and required moderate assistance with making daily life decisions. She was also coded as needing only standby assistance of one staff member to perform her activities of daily living with the exception of bathing. For bathing, she was coded as needing total assistance of one staff member.

Resident #17 was observed during medication pour and pass observation 7/27/16 beginning at 8:34 a.m. LPN A prepared Resident #17's medications and entered Resident #17's bedroom. She handed Resident #17 her medications and then proceeded to assist Resident #17's room mate with her over bed table and breakfast tray. LPN A washed her hands, washing her hands approximately 2 seconds, and turned the faucet off with a paper towel. LPN A returned to Resident #17 and assisted her with taking her medications. LPN A washed her hands again, washing her hands for approximately 2 seconds and returned to the medication cart.

When interviewed regarding her hand washing technique of only washing her hands for approximately 2 seconds, LPN A verbalized she did not realize she did not wash her hands long enough, 7/28/16 at 10:15 a.m.

Review of the facility's policy entitled "Handwashing Requirements" included:

"4. Work lather over hands and wrists.
f. Scrub for at least 15-20 seconds."

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Registered Nurse (RN) D stated 7/28/16 at 10:05 a.m., she felt the staff should wash their hands for 20-30 seconds. RN D said, "it is better to do it longer..."

Guidance is provided at www.cdc.gov:

"MMWR (Morbidity and Mortality Weekly Report), https://www.cdc.gov/mmwr/index.htmlGuideline for Hand Hygiene in Health Care Setting, 10/25/02, When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet (IB) (90-92,94,411). Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis (IB) (254,255). C. Liquid, bar, leaflet or powdered forms of plain soap."

The administrator, Director of Nursing, and corporate consultant were informed of the failure of LPN A to wash her hands an acceptable time during medication pour and pass observation for Resident #17, 7/28/16 at 11:58 a.m.

F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician.	F 504	F 504.	1) Resident #9 has received no lab draws. Resident #8 had ordered labs drawn, resulted, and MD notified of findings. 2) All residents are at risk.

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This REQUIREMENT is not met as evidenced by:

Based on resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed for one resident (Resident #9) of 27 residents in the survey sample, to ensure laboratory services were performed on the correct resident.

~~The lab drew Resident #9's blood in error~~, rather than her roommate's (Resident #8) whom the order was intended for.

The findings included:

Resident #9 was admitted to the facility on 3/4/15 with the diagnoses of, but not limited to, ESRD (end stage renal disease), vascular dementia, and adult failure to thrive.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 5/20/16. The MDS coded Resident #9 with severe cognitive impairment; required extensive assistance from staff for bed mobility, transfers, and eating and was dependent on staff for dressing, toileting, hygiene and bathing.

On 7/26/16 at 2:30 p.m. during initial tour of the facility, Resident #9 was observed lying in a reclined gerichair in her room. She did not respond or open her eyes when her name was called. The nurse present at the time stated she is end stage renal disease but no longer getting dialysis and she has a feeding tube but no tube feedings and gets pleasure food.

On 7/27/16 at 8:45 a.m. Resident #9's clinical

F 504 F 504 Continued

3) Staff Development Coordinator or designee will educate all licensed staff on ensuring that lab services draw labs on correct patient.
4) DON or designee will audit 100% of labs drawn x1 week, then 50% x3 weeks, then quarterly in following QA meeting.
5) Date of Compliance: 8/17/2016

Addendum 8/15/16:
Clarification – Patient #9 did receive lab draw in error.

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record was reviewed. The review revealed physician orders which included "Comfort Care" dated 6/2/16-No IV (intravenous) fluids, hospital, labs, weights or vital signs.

On 7/27/16 at 10:30 a.m. an interview was conducted with Unit Manager (RN-B). When Resident #9 was discussed, it was revealed that the physician ordered lab work to be done for Resident #8 on 7/13/16 but the lab tech came in and drew the lab work on Resident #9 in error. RN-B stated Resident #8, who had no cognitive impairment, was going to be sent to the hospital because of the abnormal lab results but when she was told the reason she was going to the hospital, Resident #8 stated she did not have labwork done, the roommate did. RN-B stated Resident #9 did have a bandage on her hand and Resident #8 did not. Further discussion and documentation provided by RN-B revealed the physician and responsible parties were made aware of the error.

During a conversation with Resident #9's roommate (Resident #8), on 7/27/16 at 11:40 a.m., Resident #8 confirmed that she went to the hospital due to abnormal lab results that were actually drawn on her roommate (Resident #9).

Review of the lab slip that was supplied to the lab tech on 7/13/16 did list the correct resident (Resident
#8) and bed number for the labwork to be drawn.

On 7/27/16 at 4:10 p.m. the Administrator, Director of Nursing and Corporate Nurse were informed of the findings. A "SERVICE CONCERN REPORT" for Resident #9 was presented with "Details of Concern" documented

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as:
"labs drawn on resident in error by lab. Resident is Comfort Care. RP (responsible party) aware MD (medical doctor) aware Resident resting comfortably. RP only concern was for roommate..."

No further information was provided by the facility staff.

~~F 505 483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS~~ F 505 F 505

The facility must promptly notify the attending physician of the findings.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review, and clinical record review, the facility staff failed, for 1 resident, (Resident #11) in the survey sample of 27 residents, to notify the physician of two abnormal thyroid function lab results in a timely manner.

1. For Resident #11, the facility staff failed, on two occasions to notify the physician of abnormally high thyroid function test results.

The Findings Included:

Resident #11 was an 86 year old who was admitted to the facility on 2/21/14. Resident #11's diagnoses included Thyroid Disorder, Anxiety Disorder, Major Depressive Disorder, Dementia with Behavioral Disturbance, and Schizophrenia.

The Minimum Data Set, which was an Annual

1) Resident #11 had no adverse effect from delay in notifying MD of lab result. Resident is receiving lab testing and results are being reported same day.
2) All residents at risk.
3) Staff Development Coordinator or designee will education all licensed staff on notifying MD of abnormal labs results on same day of resulting lab.
4) DON or designee will audit 100% of labs results x1 week, then 50% x3 weeks, then quarterly In following QA meeting.
5) Date of Compliance: 8/17/2016

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Assessment with an Assessment Reference Date of 6/16/16, coded Resident #11 as having a Brief Interview of Mental Status Score of 9, indicating severe cognitive impairment.

On 7/27/16 a review was conducted of Resident #11's clinical record. On 3/29/16 the results of a TSH (thyroid function) test read, "Result: 7.78 High. Reference Range 0.35 - 4.94." Also, on ~~5/12/16 the results of a TSH test read, "Result~~ 17 76 High. Reference Range 0.35 - 4.94."

There were no nursing notes, or other documentation that the physician had been notified of the results of the March 3/29/16 test. Regarding the test done on 5/12/16, the physician wasn't notified until 5/17/16.

The physician increased Resident #11's Synthroid from 150 MCG one time daily to 175 MCG one time daily. The therapeutic use of Synthroid according to Mosby's Drug Guide for Nurses (8th Ed. pp. 555) is as follows: "Therapeutic outcome: Correction of lack of thyroid hormone".

On 7/27/16 a review was conducted of facility documentation. The Laboratory Tracking Policy dated 2/1/15 read, "A licensed nurse will monitor and track all physician ordered laboratory tests, ensure that lab tests are drawn as ordered and communicate results to the physician in a timely manner. A licensed nurse will then notify the physician as soon as possible of any abnormal lab results. Results within normal limits may be faxed to the physician for notification. Critical results will be called to the physician and documented as indicated."

On 7/28/16 at 10:30 A.M. an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(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 505	Continued From page 38 conducted in the conference room with the Director of Nursing (Administration B). When asked about the importance of notifying the physician of abnormal results in a timely manner, he stated, "With a high lab, that's something you want to notify the doctor about that day." On 7/28/16 at 4:30 P.M. the Administrator (Administration A) was informed of the findings. No further information was received.	F 505		