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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495107	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY FOREST HEALTH AND REHABILITATIO	450 PINEY FOREST RD DANVILLE, VA 24540

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/20/16 through 9/22/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 107 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents 1 through 19) and 4 closed record reviews (Residents 20 through 23).	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers' allegation of compliance. All alleged deficiencies cited have been or will be corrected by 10/31/2016.	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive 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	F 272		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 10/6/16

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

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F 272	Continued From page 1 Medications, Special treatments and procedures Discharge potential Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS), and Documentation of participation in assessment This Requirement is not met as evidenced by Based on staff interview and clinical record review, the facility staff failed to document the date and location of clinical record documentation in Section V Care Area Assessment (CAA) Summary used to complete the comprehensive minimum data set (MDS) assessments for 10 of 23 residents (Resident #3, #6, #11, #12, #5, #9, #1, #13, #7, and #8) The findings included 1. The facility staff failed to ensure Section V Care Area Assessment (CAA) Summary included the date and location of documentation used to complete the significant change in assessment MDS (minimum data set) for Resident #3 The clinical record of Resident #3 was reviewed 9/20/16 and 9/21/16. Resident #3 was admitted to the facility 7/5/13 with diagnoses that included but not limited to Alzheimer's disease, type 2 diabetes mellitus, hyperlipidemia, urine retention, macular degeneration, depression, and unspecified conjunctivitis.	F 272	MDS' for residents #3, #6, #11, #12, #5, #8, #1, #13 and #8 have been reviewed. Current residents MDS assessments were reviewed and information was documented on the CAA for the location of substantiated information. MDS coordinator, Dietician, Activity Director and Director of Discharge Planning received education on how to document location of supporting documentation on the CAA. The following audit process will be implemented: 4 resident's MDS' will be audited each week for 4 weeks 3 resident's MDS' will be audited each week for 4 weeks 2 resident's MDS' will be audited each week for 4 weeks Any issues identified during the audit process will be corrected. Any non-compliance will be reviewed in the QA committee for progressive disciplinary action.	

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Resident #3's significant change in assessment MDS (minimum data set) with an assessment reference date (ARD) of 6/22/16 assessed the resident with short term memory problem, long term memory problem and severely impaired cognitive skills for daily decision making

Section V Care Area Assessment (Summary) was reviewed 9/20/16. Resident #3 triggered for these areas with the decision made to care plan each: Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence and Indwelling catheter, Behavioral Symptoms, Falls, Nutritional Status, Pressure Ulcer and Psychotropic Drug Use. Location and date of documentation for Section V read 'CAA WS (worksheet) dated 6/24/16 '

The surveyor reviewed the 6/24/16 CAA worksheets. The Cognitive Loss/dementia worksheet read "See MD (medical doctor) notes " No specific notes listed. There were specific MARs identified (6-16 through 6-22). Visual Function read "See MD consults " No specific dates or consultation was identified. The area did include the notation to "see MARs 6-16-6-22 " Communication worksheet read 'See MARs " No dates included. Urinary worksheet read "See MARs 6-16 thru 6-22" under "Diseases and Conditions' then under "Medications" the documentation read "see mars"-no specific dates. Behavioral Symptoms read 'Pt. (patient) remains cognitively impaired. Pt. will refuse care and become combative at times during care " No specific location or dates where the information was found. Falls worksheet read "see mars 6-12 thru 6-22 " Nutritional worksheet had no documentation to identify why the area was triggered and care planned. Pressure ulcer

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worksheet read "see mars." No other documentation/location was identified Psychotropic drug use worksheet read "see mars 6-12 thru 6-22."

The surveyor interviewed the MDS registered nurse on 9/20/16 at 4:45 p.m. The MDS registered nurse stated she was unable to see the documentation in Section V on the computer screen. The MDS RN also stated she knew dates needed to be documented with the MARs but that was all. The MDS RN stated she had recently been re-educated about dates on the worksheets

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above finding on 9/21/16 at 2:50 p.m. The corporate registered nurse stated the facility had "QA'ed" the issue but had not completed the 5 points.

No further information was provided prior to the exit on 9/22/16

2. The facility staff failed to ensure Section V Care Area Assessment (CAA) Summary included the date and location of documentation used to complete the significant change in MDS for Resident #6

The clinical record of Resident #6 was reviewed 9/20/16. Resident #6 was admitted to the facility 9/28/15 and readmitted 7/7/16 with diagnoses that included but not limited to ESBL (extended spectrum beta lactamase) in urine, sacral pressure ulcer, paraplegia, hypertension, heart failure, acute osteomyelitis, dysphagia, MRSA (methicillin resistant staphylococcus aureus), hyperlipidemia, colostomy, depressive disorder, and gastroesophageal reflux disease

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Resident #6's significant change in assessment MDS (minimum data set) with an assessment reference date (ARD) of 3/18/16 assessed the resident with a cognitive summary score of 6 out of 15.

A review of the significant change MDS referenced above revealed Resident #6 triggered for the following areas in Section V. Cognitive Loss/Dementia, ADL Functional/Rehabilitation, Urinary Incontinence and Indwelling Catheter, Behavioral Symptoms, Nutritional Status, and Pressure Ulcer. The location and date of CAA documentation for each item that was triggered and the decision made to care plan read "CAA WS (worksheet) dated 3/21/16." Psychosocial Well-Being and Dehydration/Fluid Maintenance were not triggered areas, however, the location and date of documentation read "CAA WS dated 3/21/16."

A review of the CAA worksheet for 3/21/16 was conducted 9/20/16. The worksheet for cognitive loss/dementia listed "See MARS (medication administration records)." There were no specific MARs listed to review. The worksheet for ADL Functional/Rehabilitation read "See wound records." There were no specific wound records identified. The worksheet for urinary incontinence and indwelling catheter had no information documented. Psychosocial Well-Being read "See behavior CAA." The Behavioral Symptoms worksheet read "Pt (patient) noted yelling at times, pt noted ringing call bell constantly at times." Nutritional Status worksheet read "See dietary notes, nursing notes. MAR with ard (assessment reference date) of 3/18/16." No specific dietary or nursing notes identified. Dehydration/Fluid Maintenance had no

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documentation as to location and date where information was found that was used to complete the comprehensive MDS. Pressure Ulcers worksheet read "See adls (activities of daily living) and see h&p (h story and physical).'

The surveyor interviewed the MDS registered nurse on 9/20/16 at 4:45 p.m. The MDS registered nurse stated she was unable to see the documentation in Section V on the computer screen. The MDS RN also stated she knew dates needed to be documented with the MARs but that was all. The MDS RN stated she had recently been re-educated about dates on the worksheets.

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above finding on 9/21/16 at 2:50 p.m. The corporate registered nurse stated the facility had "QA'ed" the issue but had not completed the 5 points.

No further information was provided prior to the exit on 9/22/16.

3. The facility staff failed to ensure Section V Care Area Assessment (CAA) summary included location and date used to complete the significant change in assessment MDS (minimum data set) for Resident #11.

The clinical record of Resident #11 was reviewed 9/20/16 and 9/21/16. Resident #11 was admitted to the facility 3/8/15 with diagnoses that included but not limited to pre-syncope secondary to vasovagal versus orthostasis secondary to dehydration, anemia, heart failure, hypertension, Non Alzheimer's dementia, rheumatoid arthritis, gout, chronic kidney disease (stage 3), and encephalopathy.

Resident #11's annual minimum data set (MDS)

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assessment with an assessment reference date (ARD) of 1/18/16 assessed the resident with a cognitive summary score of 9 out of 15 in Section C
Section V Care Area Assessment (CAA) Summary was reviewed for accuracy. Resident #11 was triggered for the following areas: Cognitive Loss/Dementia, ADL Functional/Rehabilitation, Urinary Incontinence and Indwelling Catheter, Behavioral Symptoms, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer, and Psychotropic Drug Use. The location and date to find documentation that was used to complete the annual MDS read "CAA WS dated 1/20/16."
The cognitive loss/dementia worksheet read "See MARs" as the location but there were no specific dates. ADL worksheet read "See C.N.A. (certified nursing assistant) documentation." There were no specific dates or documentation where the information was located. Urinary worksheet read "See MARs"-no specific dates or location to find documentation. Behavioral worksheet read "Pt has not been feeling well and refused shower on 1 occasion." No specific areas or dates to find the information were documented. Falls worksheet read "See MARs." Nutritional Status read "See nutrition assessment, dietary notes, nursing notes, and MAR for ard of 1/18/16." There were no specific dates identified with the location of information. Dehydration/Fluid Maintenance worksheet did not include any documentation. Pressure Ulcer worksheet read "See C.N.A. documentation and see MARs." There were no specific dates for the C.N.A. or MARs documentation. Psychotropic drug use read "See MARs." There were no specific dates documented
The surveyor interviewed the MDS registered nurse on 9/20/16 at 4:45 p.m. The MDS

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registered nurse stated she was unable to see the documentation in Section V on the computer screen. The MDS RN also stated she knew dates needed to be documented with the MARs but that was all. The MDS RN stated she had recently been re-educated about dates on the worksheets.

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above finding on 9/21/16 at 2:50 p.m. The corporate registered nurse stated the facility had "QA'ed" the issue but had not completed the 5 points.

No further information was provided prior to the exit on 9/22/16.

4. The facility staff failed to ensure section V Care Area Assessment (CAA) Summary was accurate to include the date and location of documentation used to complete the significant change in assessment MDS (minimum data set) for Resident #12.

The clinical record of Resident #12 was reviewed 9/20/16 and 9/21/16. Resident #12 was admitted to the facility 12/20/11 with diagnoses that included but not limited to urinary tract infection, hypertension, psychosis, gout, BPH (benign prostate hypertrophy), chronic airway obstruction, diabetes mellitus, dysphagia, senile dementia, Parkinson's disease, and renal failure.

Resident #12's annual MDS assessment with an ARD of 8/17/16 was reviewed for accuracy on 9/21/16. Resident #12 was assessed with a cognitive summary score of 8 out of 15 in Section C. Section V Care Area Assessment (CAA) Summary identified the following triggered areas: Cognitive Loss/Dementia, ADL, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcers, and Psychotropic Drug Use. The location

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and date used to complete the annual MDS read "CAA WS dated 8/18/16." ADL function read "See C N A documentation." There were no specific dates where the information was found. Urinary Incontinence and Falls worksheets read "See MARs 8-11 thru 8-17." Nutritional Status worksheet read "see nutrition assessment, dietary notes, nursing notes, MAR for ard of 8/17/16." There were no specific dates documented. Pressure Ulcer worksheet read "See C N A documentation and see MARS 8-11-thru 8-17."
The surveyor interviewed the MDS registered nurse on 9/20/16 at 4:45 p.m. The MDS registered nurse stated she was unable to see the documentation in Section V on the computer screen. The MDS RN also stated she knew dates needed to be documented with the MARs but that was all. The MDS RN stated she had recently been re-educated about dates on the worksheets.

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above finding on 9/21/16 at 2:50 p.m. The corporate registered nurse stated the facility had "QA'ed" the issue but had not completed the 5 points.

No further information was provided prior to the exit on 9/22/16.
5. For Resident #5, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/16/16.

The record review revealed that Resident #5 had been admitted to the facility 12/13/11. Diagnoses

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included, but were not limited to, dementia, diabetes, hypothyroidism, gout, hypertension, and anemia.

Section C (cognitive patterns) of the Residents significant change in status MDS assessment with an ARD of 02/16/16 had a BIMS (brief interview for mental status) summary score of 9 out of a possible 15 points

The directions under section V of this assessment read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. "

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented "CAA WS (worksheet) dated 2/18/2016" for the triggered areas of cognitive loss, ADL (activities of daily living), incontinence, behavioral symptoms, nutritional status, dehydration/ fluid, and pressure. The actual ocation(s) regarding the documentation had not been documented

When reviewing the CAA WS the surveyor was only able to locate dates and location of the supporting documentation for the triggered area of nutrition.

On 09/20/16 at approximately 3:50 p.m. during an interview with RN (registered nurse) #1, who was the MDS coordinator, was asked about the missing documentation. RN #1 verbalized to the surveyor that this MDS had been completed before she had been re-educated in regards to the missing dates

The administrative team was made aware of the

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missing MDS information during meetings with the survey team on 09/21/16 and 09/22/16

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

6. For Resident #9, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/19/16.

The record review revealed that Resident #9 had been admitted to the facility 01/12/16. Diagnoses included, but were not limited to, hemiplegia, diabetes, atrial fibrillation, hypertension, depressive disorder, and chronic kidney disease.

Section C (cognitive patterns) of the Residents admission MDS assessment with an ARD of 01/19/16 had a BIMS (brief interview for mental status) summary score of 14 out of a possible 15 points.

The directions under section V of this assessment read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..."

Under the column labeled "Location and Date of CAA documentation" the facility staff had documented "CAA WS (worksheet) dated 1/20/2016" for the triggered areas of ADL's (activities of daily living), incontinence, falls, nutrition, pressure, and psychotropic drug use. The actual location(s) regarding the documentation had not been documented.

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When reviewing the CAA WS the surveyor was unable to locate the dates and location of the supporting documentation for the above triggered areas.

On 09/20/16 at approximately 3:50 p.m. during an interview with RN (registered nurse) #1, who was the MDS coordinator, was asked about the missing documentation. RN #1 verbalized to the surveyor that this MDS had been completed before she had been re-educated in regards to the missing dates.

The administrative team was made aware of the missing MDS information during meetings with the survey team on 09/21/16 and 09/22/16.

No further information regarding this issue was provided to the survey team prior to the exit conference.
7 The facility staff failed to complete the Care Area Assessment Summary (CAA) on the Minimum Data Set for Resident #1.

Resident #1 was admitted to the facility on 4/15/16 with diagnosis of hypertension, dementia, depression, dysphagia, and pneumonia.

The significant change Minimum Data Set (MDS) with a reference date of 8/16/16 was reviewed. The MDS assessed the resident with a cognitive score of "4" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers, dressing, eating, bathing, and hygiene.

Section "V" for Care Area Assessment Summary (CAA) was reviewed. The area for location and date of CAA documentation stated, "CAA WS

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(work sheet) dated 8/18/16" Each work sheet for the areas triggered for care planning decision making noted the location of documentation was the "CAA WS dated 8/17/16" or "CAA WS dated 8/18/16" Some of the areas contained additional notation to see "Dietary notes, nursing notes. and MAR for ARD of 8/16/16" The dates for the notes were not identified.

The MDS coordinator (RN#2) stated the computer system did not allow viewing of "Section V" and so she was not aware the date and location of CAA information did not reveal where the information was located.

The administrator, director of nursing, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 9/21/16 at 4 00 p m

8 The facility staff failed to complete the Care Area Assessment Summary (CAA) on the Minimum Data Set for Resident #13

Resident #13 was admitted to the facility on 3/10/16 with diagnosis of cancer of the colon, hypertension, depression with psychosis, anemia, coronary artery disease, stroke, pressure ulcer, and atrial fibrillation.

The admission Minimum Data Set (MDS) with a reference date of 3/17/16 was reviewed. The MDS assessed the resident with a cognitive score of "13" of "15" The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers, dressing, eating, bathing and hygiene

Section "V" for Care Area Assessment Summary (CAA) was reviewed . The area for location and

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PINEY FOREST HEALTH AND REHABILITATIO	450 PINEY FOREST RD DANVILLE, VA 24540

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date of CAA documentation stated , "CAA WS (work sheet) dated 3/21/16". Each work sheet for the areas triggered for care planning decision making noted the location of documentation was the "CAA WS dated 3/21/16" or "CAA WS dated 8/18/16". Some of the areas contained additional notation to see "Dietary notes, nursing notes, and MAR for ARD of 3/21/16" The dates for the notes were not identified.

The MDS coordinator (RN#2) stated the computer system did not allow viewing of "Section V" and so she was not aware the date and location of CAA information did not reveal where the information was located.

The administrator, director of nursing, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 9/21/16 at 4:00 p.m.

9 The facility staff failed to document the location of where the documentation could be found in Resident #7 ' s clinical record for Section V of the Care Area assessment (CAA) Summary of the Minimum Data Set (MDS).

Resident #7 was readmitted to the facility on 4/27/16 with the following diagnoses of, but not limited to Atrial Fibrillation, dementia, anxiety disorder, depression, mood disorder, thyroid disorder and high cholesterol. The most recent MDS was a significant change assessment with an ARD (Assessment Reference Date) of 7/28/16 scored the resident as having short term and long term memory problems. The resident was also coded as requiring extensive assistance of one staff member for bathing and personal hygiene. The resident is totally dependent on one staff member for bathing.

The surveyor reviewed the clinical record of Resident #7 on 9/20/16. The surveyor noted that

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on the significant change MDS with an ARD of 7/28/16 in Section V of the CAA Summary the location and/or dates of the documentation to support the triggered area for the following were not documented: Cognitive Loss/Dementia, Visual Function, Communication, Pressure Ulcer and Psychotropic Drug Use. The dates were also not documented on the CAA Worksheets dated for 7/29/16.

The MDS nurse was interviewed on 9/21/16 at approximately 3 pm in the MDS office and was notified of the above documented findings. The MDS nurse stated " I don ' t put the dates or location on the CAA section but I have been educated about this now. "

The administrator, director of nursing and assistant director of nursing was notified of the above documented findings in the end of the day conference on 9/21/16 at approximately 2:30 pm.

No further information was provided to the surveyor prior to the exit conference on 9/22/16.

10. The facility staff failed to document the location of where the documentation could be found in Resident #8 ' s clinical record for Section V of the Care Area Assessment (CAA) Summary of the Minimum Data Set (MDS).

Resident #8 was readmitted to the facility on 7/10/15 with the following diagnoses of, but not limited to: high blood pressure, peripheral vascular disease, seizures, anxiety, depression, osteoporosis, and dementia. The most recent MDS was a significant change assessment with an ARD (Assessment Reference Date) of 7/9/16 scored the resident as having a BIMS (Brief Interview Mental Status) score of 4 out of a possible score of 15. The resident was also coded as requiring extensive assistance of one staff member for dressing and personal hygiene. The resident is totally dependent on one staff member for bathing.

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F 272	Continued From page 15 The surveyor reviewed the clinical record of Resident #8 on 9/21/16. The surveyor noted that on the significant change MDS with an ARD of 7/10/16 in Section V of the CAA Summary the location and/or dates of the documentation to support the triggered area for the following were not documented Cognitive Loss/Dementia, Visual Function, Behavior Symptoms, and Psychotropic Drug Use. The dates were also not documented on the CAA Worksheets dated for 7/11/16 The MDS nurse was interviewed on 9/21/16 at approximately 3 pm in the MDS office and was notified of the above documented findings The MDS nurse stated " I don ' t put the dates or location on the CAA section but I have been educated about this now. " The administrator, director of nursing and assistant director of nursing was notified of the above documented findings in the end of the day conference on 9/21/16 at approximately 2:30 pm No further information was provided to the surveyor prior to the exit conference on 9/22/16	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care This Requirement is not met as evidenced by Based on observation, staff interview, and clinical record review, the facility failed to follow physician ' s orders for 1 out of 23 residents (Resident #14)	F 309		

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The findings included:

Resident #14 was readmitted to the facility on 12/1/14 with the following diagnoses of, but not limited to high blood pressure, arthritis, dementia, Schizophrenia, and peripheral vascular disease. The annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/27/16 coded Resident #14 as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene.

During the Medication Administration Observation on 9/21/16 at 9:10 am, the surveyor observed LPN (Licensed Practical Nurse) #4 giving Resident #14 Geodon 40 mg (milligram) 1 capsule by mouth. The surveyor reviewed the clinical record of Resident #14 on 9/21/16 at approximately 10:00 am. In the physician orders dated and signed for 9/1/16, the following order was noted: " Geodon 20 mg give 1 capsule by mouth one time a day ... and Geodon 40 mg 1 capsule by mouth one time a day ... " On the MAR (Medication Administration Record) dated for the month of September, 2016, the following was noted: " Geodon 20 mg give 1 capsule by mouth one time a day " and the time to be administrated to the resident was 1000 (10:00) am. The surveyor also noted on the resident's MAR for September " Geodon 40 mg give 1 capsule by mouth one time a day ... " and the time listed on the MAR for the resident to be administrated this medication was 2200 (10:00 pm).

The surveyor interviewed LPN #4 on 9/21/16 at approximately 11:00 am. LPN #4 stated to the

Resident #14's physician was notified of the medication error at the time of the survey.

Current residents that are receiving Geodon were audited and orders were verified with the physician for correct dosage.

Licensed staff were educated on proper verification of medication administration using the 5 R's. Right resident, right medication, right route, right dose, and right time by the Staff Development Coordinator (SDC).

SDC/Unit Manager/DON/Designee will complete medication pass observations as follows:

4 per week for 4 weeks

3 per week for 4 weeks

2 per week for 4 weeks

Any issues will be corrected at the time of the observation.

Any non- compliance will be reviewed in the QA committee for progressive disciplinary action.

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surveyor " I should have given the 20 mg of Geodon instead of the 40 mg that I gave I will let the doctor know. "

The administrator, director of nursing and the regional nurse for corporate were notified of the above documented findings on 9/21/16 at 2.30 pm The surveyor asked for a copy of the policy on medication administration.

The director of nursing gave the surveyor a copy of the policy titled " 6.0 General Dose Preparation and Medication Administration " on 9/22/16 at approximately 9 am. It was noted by the surveyor that in Section 4 of the Medication Administration policy it stated the following:
" 4.1 Facility staff should
4 1 1 Verify each time a medication is administrated that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident ... "

No further information was provided to the surveyor prior to the exit conference on 9/22/16.

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

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 interview, the facility staff failed to maintain essential equipment in the laundry room.

The findings included.

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F 456	Continued From page 18 The areas around the washing machines in the laundry room had not been cleaned and were observed by the surveyor to have debris that included lint, coat hangers, paper, and lids scattered behind and beside the washing machines On 09/21/16 beginning at approximately 12:30 p.m., the surveyor toured the laundry room. During this observation the surveyor noted that the area beside and behind the washing machines had not been cleaned. The surveyor was able to observe lint, broken coat hangers, paper, and plastic lids scattered around the wash machines. During this observation LP (laundry personnel) #3 was asked who was responsible for cleaning this area. LP #3 stated she was unsure. LP #2 then verbalized that we are responsible. The surveyor then asked to speak with the housekeeping/laundry supervisor. On 09/21/16 at approximately 12:40 p.m. the supervisor entered the laundry room and was shown the debris around the wash machines. The supervisor stated he would have the area cleaned today The administrative staff were notified of the above in a meeting with the survey team on 09/21/16 at approximately 2:45 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference	F456	Area around the washer and the laundry room was cleaned at the time of survey. Laundry staff have been educated by the Environmental Services Director on keeping the laundry room clean and free of debris. Environmental Services Director/Designee will inspect the laundry room as follows: 3 times per week for 5 weeks 2 times per week for 4 weeks 1 time per week for 3 weeks Any non- compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action as needed.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness	F 502		

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F 502	Continued From page 19 of the services	F502	Resident #6's physician was notified at the time of survey that the lab test was not obtained. Current residents receiving Vancomycin medication orders were reviewed and lab work orders were obtained from the physician as needed and notified of any missing lab test. Licensed staff were educated on the documentation policy for medication administration by Staff Development Coordinator (SDC). SDC/DON/ Unit Manager/Designee will monitor lab tracking form daily to assure that all ordered labs are obtained and if not notify the physician. Any non- compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action as needed.	

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 laboratory test for 1 of 23 residents (Resident #6).

The findings included:

The facility staff failed to obtain a vancomycin trough and creatinine level for Resident #6 as ordered for 8/15/16.

The clinical record of Resident #6 was reviewed 9/20/16. Resident #6 was admitted to the facility 9/28/15 and readmitted 7/7/16 with diagnoses that included but not limited to ESBL (extended spectrum beta lactamase) in urine, sacral pressure ulcer, paraplegia, hypertension, heart failure, acute osteomyelitis, dysphagia, MRSA (methicillin resistant staphylococcus aureus), hyperlipidemia, colostomy, depressive disorder, and gastroesophageal reflux disease.

Resident #6's significant change in assessment MDS (minimum data set) with an assessment reference date (ARD) of 3/18/16 assessed the resident with a cognitive summary score of 6 out of 15.

The clinical record contained a physician order dated 8/9/16 that read "Vanc trough and creatinine-one time only for vanc therapy until 8/15/16."

A review of the laboratory section, both electronic documentation and paper charting, failed to produce the results of both laboratory tests

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F 502	Continued From page 20 ordered for 8/15/16. The surveyor reported the concern to the staff development coordinator on 9/21/16 at 8:55 a.m The SDC provided the tracking form that she kept for laboratory testing. On the form, the Vanc trough and creatinine ordered on 8/9/16 and to be done 8/15/16 was entered. The SDC stated the contracting laboratory initialed the tracking form when the laboratory test had been obtained. The lab tracking form had been initialed by "PM." At 10 40 a.m , the SDC stated the laboratory technician was notified and wanted to check her manifest at the laboratory office. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the failure of the facility staff to obtain the physician ordered laboratory tests in the end of the day meeting on 9/21/16 at 2:50 p m The SDC stated that the Vancomycin trough and creatinine levels ordered for 8/15/16 were not done No further information was provided prior to the exit conference on 9/22/16	F 502		
F 514 SS=D	483 75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete accurately documented; readily accessible and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments, the plan of care and	F 514		

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F 514	Continued From page 21 services provided, the results of any preadmission screening conducted by the State, and progress notes. This Requirement is not met as evidenced by Based on staff interview and clinical record review, the facility failed to maintain a complete and accurate clinical record for 1 of 23 residents (Resident #4) The findings included Resident #4 was readmitted to the facility on 9/30/13 with the following diagnoses of, but not limited to anemia, high blood pressure, diabetes, seizures, anxiety, Schizophrenia and dysphagia The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/25/16 was coded as having a BIMS (Brief Interview for Mental Status) score of 4 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene. The resident was totally dependent on 1 staff member for bathing according to this MDS. The surveyor reviewed Resident #4 ' s clinical record on 9/21/16. On the MAR (Medication Administrated Record) dated for September, 2016, there was documentation missing on the 9/11/16 for the evening shift that the medications were administrated. The administrator, director of nursing and regional nurse from corporate was asked to provide a copy of the MAR for Resident #4 dated for the month of September, 2016 on 9/21/16 at 2:30 pm.	F514	Resident #4's MAR was corrected at the time of the survey. Current resident's MARs were audited for the month and any holes were corrected at the time, physicians were made aware of any missed medications. Licensed staff were educated on the documentation policy for medication administration by Staff Development Coordinator (SDC). Unit Managers/DON/Designee will monitor missed administration report daily and have corrections made as indicated. Any non-compliance will be reported to QA committee for tracking and trending and progressive disciplinary action as needed. RECEIVED OCT 11 2016 VDH/OLC	

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On 9/22/16 at 8:30 am, the director of nursing provided the above requested MAR for Resident #4 to the surveyor. The surveyor reviewed the MAR that was given. The holes were noted on the MAR for missing documentation on 9/11/16 for the evening shift. At 8:40 am, the director of nursing reviewed the MAR for Resident #4 with the surveyor. The surveyor showed the director of nursing (DON) the missing documentation on 9/11/16. The DON stated to the surveyor that she would look into this. The DON returned to the surveyor at 9 am with copies of the above MAR dated for the month of September, 2016. The surveyor reviewed these copies and there were no holes or missing documentation on 9/11/16 for the evening shift. The surveyor asked the DON about this and showed her the MAR that the DON just gave the surveyor. The DON stated, " I went to the nurse that needed to document these and she was working today, so she fixed it. I don ' t have the permission in the computer to fix things like this. Only the nurse that was documenting for that day and shift can fix something like this. "

No further information was provided to the surveyor prior to the exit conference on 9/22/16.

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F 000	Initial Comments	F 000		

An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 9/20/16 through 9/22/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 120 certified bed facility was 107 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents 1 through 19) and 4 closed record reviews (Residents 20 through 23).

F 001 Non Compliance — F 001

The facility was out of compliance with the following state licensure requirements.

This RULE is not met as evidenced by:
The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.

12 VAC 5-371-250 Resident assessment and care planning
12 VAC 5-371-250 (A.1 THRU A.14) Cross Reference to F-272

12 VAC 5-371-220 Quality of Care
12 VAC 5-371-220 (A THRU G) Cross reference to F-309

12 VAC 5-371-370 Physical Environment
12 VAC 5-371-370 (b) Cross reference to F-456

12 VAC 5-371-310 Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 001	Continued From Page 1 12 VAC 5-371-310 (A) Cross reference to F-502 12 VAC 5-371-360 Clinical Records 12 VAC 5-371-360 (A, E, f, j) Cross Reference to F-514	F 001		