State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495332	A. BUILDING _____ B. WING _____	07/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE HEALTHY LIVING COMMUNITY-SMITHF	101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 7/5/16 through 7/7/16. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 34 bed facility was 26 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents #1 through 10).	F 000	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. All corrective actions will be implemented by the close of business on 8/5/16.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5-371-220. Nursing Services (B). Cross Reference F 329 12 VAC 5-371-340 (A). Dietary and Food Service Program Cross Reference F 371 12 VAC 5-371-360 (E. 4, 9). Clinical Records Cross Reference F 514 12VAC5-371-360 (A) (E, (4,6). Please Cross-Reference to F-514	F 001	**F-001** 1) 12 VAC 5-371-220 – Please cross reference to F-329. 2) 12 VAC 5-371-340 (A) – Please cross reference F-371. 3) 12 VAC 5-371-360 – Please cross reference F-514 4) 12 VAC 5-371-360 – Please cross reference F-514	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy Knox, Administrator		7/20/16

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

PRINTED: 07/12/2016
FORM APPROVED
OMB NO. 0938-0391

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F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 7/5/16 through 7/7/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term requirements. The Life Safety Code survey/report will follow. The census in this 34 certified bed facility was 26 at the time of the survey. The survey sample consisted of 10 current resident reviews (Residents #1 through 10) and 3 closed record reviews (Resident #11 through 13).	F 000		
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 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.	F 329	RECEIVED AUG 03 2016 VDH/OLC **F-329** 1) Resident #5's Cipro was d/c'd on 6/27/16. The resident experienced no adverse outcomes from the extra doses. 2) Residents with new antibiotic orders are identified as having potential to be affected by the alleged deficient practice. A 100% audit was completed for current resident population for all antibiotics requiring "STOP" dates was completed on 7/11/16. No other occurrences were identified. 3) Nursing staff will be re-educated to obtain "STOP" dates for all non-prophylactic antibiotics by the DON or designee. Nursing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Knox, Administrator | TITLE | (X6) DATE: 8/3/16

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 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to ensure 1 of 13 residents in the survey sample drug regimen was free of an unnecessary drug, Resident #5. Resident #5 was administered Cipro (an antibiotic) to treat a urinary tract infection (UTI) for an excessive duration. The Cipro order dated 6/16/16 was to administer Cipro 250 mg (milligrams) twice a day for 5 days. Due to a transcription error the resident received an unnecessary additional 13 doses of Cipro. The findings included: Resident #5 was admitted to the facility on 6/15/16 following a hospitalization. The resident's diagnoses from the hospital included a UTI, anemia due to a gastrointestinal bleed and hypertension. The admission MDS (Minimum Data Set) with an assessment reference date of 6/22/16 coded the resident as scoring a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had moderately impaired daily decision making skills. The physician admission orders dated 6/15/16 included: Keflex (an antibiotic) 500 mg one by mouth twice a day for 6 days to treat the UTI. On 6/16/16 the facility received a fax from the	F 329	staff will be re-educated by the DON or designee to check for "STOP" dates during the 24-Hour chart check and ensure that "STOP" dates have been transcribed to the MAR as a part of the process. 4) DON or designee will audit all new antibiotic orders, order transcription to the MAR and compared to the 24-hour chart checks to ensure accuracy weekly for four weeks. Audits will be reviewed by DON for variances. Variances will be investigated, corrections made as appropriate, and responsible staff will be re-educated as needed. Variances will be evaluated for trends and patterns and reported to the QA Committee for recommendation. 5) Corrective action will be completed by 8/5/16. Monitoring will be on-going based on QA Committee recommendation.	

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F 329	Continued From page 2	F 329		

Physician Assistant (PA) at an offsite clinic to discontinue the Keflex. The PA order was to discontinue the Keflex and start Cipro 500 mg twice a day for 5 days/ ten doses. The urine culture result received at the clinic on 6/16/16 evidenced a mixed culture growth of the organisms (Morganella morganii) and Enterococcus faecalis. Both of these organisms were susceptible to Cipro.

The Keflex was discontinued on the Medication Administration Record (MAR). The nurse failed to transcribe the complete order onto the MAR on 6/16/16. The nurse wrote the order as: Cipro 500 mg 1 tab po (by mouth) for UTI. The nurse failed to include the duration date of 5 days.

Per a pharmacy email to the administrator on 7/7/16, the pharmacy sent a communication memo in a tote on 6/16/16 requesting a stop date for the Cipro, in addition the email indicated the pharmacy had sent a total of 33 Cipro pills on that same day.

The clinical record included a pharmacy request to clarify the stop date on an electronic MAR for the Cipro entry.

The physician addressed the stop date on 6/17/16 at 11:26 a.m. The clarified order was for Cipro 500 mg one tablet by mouth twice a day for 5 days.

The clarified order was not transcribed onto the MAR. The original handwritten order was not corrected to include the stop date of 5 days.

The resident received the first dose of the Cipro on the evening of 6/16/16 and continued to

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F 329	Continued From page 3 receive it twice a day until 6/27/16. The Cipro should have stopped on the morning of 6/21/16 Instead of receiving 10 doses of Cipro, the resident received a total of 23 doses (13 unnecessary doses of Cipro.) The nurse mentor/ household RN (Registered Nurse) on the skilled nursing unit was interviewed on 7/6/16 at 2:10 p.m. The above findings was shared. After reviewing the order and the MAR the nurse stated, "He received a lot more than the 5 days...when the order came through the stop date was not transcribed to the MAR." The facility document titled, Reviewing and Transcribing Physician Orders Documenting Medications and Treatments (not dated), read in part under Procedure for Transcribing Physician Orders: 1. Review the order for clarity and completeness. If the order is not clear or complete, contact the physician giving the order an obtain clarification. Discontinue the original order and write a new order that is clear and complete. Document that the new order is a "clarification order". 2. Transcribe the new order onto the appropriate Medication or Treatment Administration record or tracking log. Write a new entry on the appropriate MAR or TAR that includes the date that the order was received, the date the order is to be implemented, and the complete order. On 7/7/16 at 12:45 p.m., the above findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting. An opportunity for additional information was offered at this time.	F 329		
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=F	Continued From page 4 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to store, prepare and serve food in a sanitary manner. The findings include: An initial inspection of the facility kitchen was conducted on 6/5/16 at 1:15 p.m. The kitchen tour and inspection was conducted with the Sous-Chef in attendance. During the inspection the following was observed: 1. Opened and cooked food product stored inside the service reach in refrigerator were not in their original container, not labeled or outside their expiration date as follows: a large container of baked potatoes was not dated, a blueberry cheesecake was not dated, a large container of prunes was dated as opened on 3/19/16, a large jar of pickles was not dated or stored in the original container, a container of cooked breakfast meats was not dated. 2. The top inside door panel and insulation strip of the reach in freezer containing stored ice cream products were observed with a black mold	F 371	**F-371** 1) The food items found opened, unlabeled and not dated were immediately disposed of. The inside freezer door was cleaned on 7/7/16. Temperatures of all refrigerators and freezers were immediately checked and were within range. Food was immediately removed from the steam table and from the residents and discarded. New food at appropriate temperature range was provided. Staff members were immediately re-educated by the Director of Dining Services and Household Mentor on acceptable safe food temperature ranges, on what to do if food is found below the safe range, and on infection control practices when taking food temperatures. 2) All residents are identified as having the potential to be affected by the alleged deficient practice in food, sanitation, and	

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F 371	Continued From page 5 like substance. 3. Daily recorded temperature logs for prepared foods was nowhere to be found inside the kitchen. The daily monitoring and recorded temperature logs for the reach in freezers and reach in refrigerators were blank from 6/23/16 through 7/5/16. The Food Service Director (FSD) joined the tour towards the end. The findings of the missing temperature recorded logs was shared. The FSD stated she kept them in a binder in her office. The FSD located the binder and it did not contain the food temperature logs. The FSD stated, "I don't know where they are...if they weren't recorded I guess they weren't done". The FSD and the Sous-Chef both stated they recently conducted an Inservice for the dietary staff. The Inservice was provided for review. The Inservice dated 6/22/16 titled Dietary Survey Readiness & General Information included: 1. A cleaning schedule. 2. The Food Safety & Sanitization Checklist included: 4. Are refrigerator temperatures monitored and recorded. 6. Are freezer temperatures monitored and recorded. 14. Does the facility identify food not stored in its original container by its proper name. 5. Are thermometers properly sanitized before using. 6. Are food temps in storage monitored and recorded. 14. Is hot food held at or above 140 degrees F (Fahrenheit) 18. Are the freezers clean inside and out. A dinner observation was conducted on 6/5/16 at 4:50 p.m., in the resident dining room. An electric heating table was observed with multiple metal containers holding food. There were gaps between each metal container holding the hot	F 371	food temperature management. No food-borne illnesses have been observed during or since the review period. 3) Staff are continuing to be re-educated by the Director of Dining Services and designees on labeling and dating all opened food. The evening Cook and/or Homemaker will audit all refrigerators and freezers prior to leaving each day to ensure that all opened food items are labeled and dated. This will be placed on the daily assignment sheet. The Cooks and Homemakers will be educated by the Director of Dining Services or designee on the new process. The door insulation strip on the reach-in refrigerators has been added to the weekly cleaning schedule. The Homemakers will be educated by the Director of Dining Services or designee on the new process. The staff have been re-educated the Director of Dining Services or designee on the process of taking and documenting the temperatures of the refrigerators and freezers	

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F 371	Continued From page 6 food items, allowing for a loss of temperature from the heating table. At 4:53 p.m., Home-maker #1 was observed taking the food temperatures of the food items on the electric heating table. The following temperatures were obtained and recorded: sliced ham-120 F, chicken tenders-101 F, asparagus 120-F, vegetable beef soup-120 F, mechanical chopped ham-100 F, pureed ham-100 F, pureed mixed vegetables-130 F, mashed potatoes-120 F. All of these food products were under the acceptable holding range of 140 F. The Home-maker used a wet paper towel to clean the thermometer between each use. The Home-maker then began to plate meals. Twelve residents in the dining room were served their meals. The Home-maker was interviewed during the plating of the meals. She was asked what the safe temperature range was for the hot foods. She stated, "They should be around 160 degrees or over...155 should be the lowest". The home-maker continued to plate the food. During this dining observation the FSD entered the dining area. The findings of the temperatures was shared with the FSD. The FSD stated the hot foods should be maintained at 145 degrees or above and cold foods at 41 degrees or below. The FSD stated if the hot food is not holding at the appropriate temperature it should be reheated by either returning it back to kitchen or heat it using the conventional oven located on the unit. The FSD was asked why the food was still being plated and served at this time knowing the temperatures were below the target range. The	F 371	daily. The evening Cook will review the temperature logs to ensure they have been completed each day prior to leaving. This will be placed on the daily assignment sheet. The Cooks will be educated the Director of Dining Services or designee on this process. The facility has implemented a system change to include: Food is transported from the Central Kitchen to the Willow Creek kitchen in a pre-warmed warming cabinet. The temperature of the food is taken prior to transfer to the cabinet to insure it is above 140 degrees. Additional pans have been procured for the steam table to ensure there are no air gaps between the pans. Food items remain in the heating cabinet until time of service. Temperatures are taken prior to service to ensure that they are above 140 degrees. Food temperatures will be taken after the last plate has been served to ensure that temperatures have been maintained. A new temperature log has been developed to reflect the new process.	

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F 371	Continued From page 7 FSD then immediately instructed the staff to remove the meals from the residents and sent the remaining food items back to the kitchen to reheat. On 6/6/16 a lunch observation was conducted in the resident dining room. Home-maker #2 was observed taking each food temperature. On top of the electric heating table were several unopened alcohol swabs. Standing next to the Home-maker was the FSD who was recording the temperatures. While obtaining the temperatures of each food item, the Home-maker was observed using the same alcohol swab to sanitize the thermometer. The facility's Policy and Procedure titled "Central Kitchen-Food Temperatures at Service Time" read, in part: "1. All hot food items will be served to the resident at the temperature of at least 140 F. When temperature is not above 140 F., the food item will be reheated to 165 F for 15 seconds in the microwave oven or stove top oven. 6. Food temperatures will be taken using a clean, rinsed and sanitized air-dried metal stem type thermometer...7. To test the temperature of a hot food before serving, insert the thermometer at a 45-degree angle to the middle of the food item...Read the thermometer and remove thermometer from food item and immediately wipe with soapy hot water, sanitize with alcohol wipe, and air-dry. 9. Temperatures should be taken periodically to ensure that hot foods stay above 140 F and cold foods stay below 40 F unit served to the resident." The above findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting conducted at 12:45 p.m. The	F 371	Homemaking staff have been re-educated the Director of Dining Services or designee on food temperature standards, what to do if the food temperatures fall below 140 degrees, the new food service system change above and on infection control standards related to taking food temperatures. 4) The Director of Dining Services or designee will inspect all refrigerators and freezers twice weekly for four weeks to ensure that all opened food items have been labeled and dated. Audits will be reviewed by Director of Dining Services for variances. Variances will be investigated, corrections made as appropriate, and responsible staff will be re-educated as needed. Variances will be evaluated for trends and patterns and reported to the QA Committee for recommendation. The Director of Dining Services or designee will inspect the insulation strips on all reach-in refrigerators and freezers to ensure that they have been cleaned weekly for four weeks. Audits will be reviewed by DON for variances. Variances will be investigated, corrections made	

as appropriate, and responsible staff will be re-educated as needed. Variances will be evaluated for trends and patterns and reported to the QA Committee for recommendation.

The Director of Dining Services will review all refrigerator and freezer temperature logs twice weekly for four weeks to ensure temperatures are being logged consistently. Audits will be reviewed by Director of Dining Services for variances. Variances will be investigated, corrections made as appropriate, and responsible staff will be re-educated as needed. Variances will be evaluated for trends and patterns and reported to the QA Committee for recommendation.

Household Mentors or designee will observe the Homemakers three times weekly for four weeks to ensure food temperatures are being checked as planned; that the warming cart is being pre-heated for food transport; that food is being transported in the warming cart; that the food remains in the

warming cart until time of service; that food temperatures are being taken using the correct infection control standards. Audits will be reviewed by Administrator for variances. Variances will be investigated, corrections made as appropriate, and responsible staff will be re-educated as needed. Variances will be evaluated for trends and patterns and reported to the QA Committee for recommendation.

5) Corrective action will be completed by 8/5/16. Monitoring will be on-going based on QA Committee recommendation.

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F 371	Continued From page 8 Administrator stated they had identified earlier in the year that food items were not holding temperature. She stated they had originally been serving the food using an induction system. They then implemented transporting the food in a warming cabinet and using an electric steam table, and the food was not still not holding temperature. They then implemented preheating the heating cabinet.	F 371		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, staff interviews, and facility document review the facility staff failed to maintain complete and accurate clinical records in accordance with accepted professional standards for 2 of 13 residents in the survey sample, Resident's #5 and #6. 1. The facility staff failed to ensure that Resident	F 514	**F-514** 1) An order clarification was received for Resident #6 regarding DNR status immediately on 7/6/16. Resident #5's Cipro was d/c'd on 6/27/16. 2) Residents with new DNR orders are identified as having potential to be affected by the alleged deficient practice. A 100% audit of all current facility residents was completed to ensure that the current code status was accurate on the Physician Order Set (POS) for July. No other occurrences were identified. Residents with new antibiotic orders are identified as having potential to be affected by the alleged deficient practice. A	

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F 514	Continued From page 9 #6's clinical record was accurate in regards to the resident's signed Durable Do Not Resuscitate Order on 6/28/16 from the Virginia Department of Health. 2. The June 2016 Medication Administration Record (MAR) for Resident #5 was inaccurate. Due to a transcription error on the MAR, the resident received an additional 13 doses of Cipro. The findings included: 1. Resident #6 was a 53 year old admitted to the facility on 6/23/16 with diagnoses to include *Right Total Knee Replacement, *Asthma, *Sleep Apnea, and *Cerebral Palsy. *Total Knee Replacement: the surgical insertion of a hinged prosthesis performed to relieve pain and restore motion to a knee severely affected by osteoarthritis, rheumatoid arthritis, or trauma. *Asthma: a respiratory disorder characterized by recurring episodes of paroxysmal dyspnea, wheezing on expiration and/or inspiration caused by constriction of the bronchi, coughing, and viscous mucoid bronchial secretions. *Sleep Apnea: a sleep disorder characterized by periods in which respiration is absent. *Cerebral Palsy: a motor function disorder caused by a permanent, nonprogressive brain defect or lesion present at birth or shortly thereafter. The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health	F 514	100% audit was completed for current resident population for all antibiotics requiring "STOP" dates was completed on 7/11/16. No other occurrences were identified. 3) Nurse Mentor was re-educated by the DON on 7/7/16 to check code status during monthly POS review to ensure the code status listed is accurate prior to signing. Providers will be re-educated by the DON or designee to ensure current code status listed on the POS is accurate prior to signing and dating. Tracking system will be put in place to be maintained by Household Mentors to track resident's code status in comparison to current order for all new admissions. Nursing staff will be re-educated by the DON or designee to obtain "STOP" dates for all non-prophylactic antibiotics. Nursing staff will be re-educated by DON or designee to check for "STOP" dates during the 24-Hour chart check and ensure that "STOP" dates have been transcribed to the MAR as a part of the process.	

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F 514	Continued From page 10 Professions 8th Edition. The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission with an Assessment Reference Date (ARD) of 6/30/16. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #6 was cognitively intact and capable of decision making. A review of Resident #6's Physician Progress Note dated and physician signed on 6/24/16 documented in part, as follows: Directives: FULL CODE On 6/28/16 Resident #6 and the Attending Physician signed a Virginia Department of Health Durable Do Not Resuscitate Order which documented in part, as follows: Physician's Order: I , the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify: 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. Resident #6's Interdisciplinary Care Plan dated 6/29/16 was reviewed and documented in part, as follows:	F 514	4) Nurse Mentors will be re-educated by the DON or designee to ensure code status is correct on physician orders/POS during monthly POS review. The DON or designee will review all active POS's monthly for three months to ensure resident code status and physician orders are accurate. Audits will be reviewed by DON for variances. Variances will be investigated, corrections made as appropriate, and responsible staff will be re-educated as needed. Variances will be evaluated for trends and patterns and reported to the QA Committee for recommendation. DON or designee will audit all new antibiotic orders, transcription to the MAR and compare to the 24-hour chart checks to ensure accuracy weekly for four weeks. Audits will be reviewed by DON for variances. Variances will be investigated, corrections made as appropriate, and responsible staff will be re-educated as needed. Variances will be evaluated for trends and patterns and reported to the QA Committee for recommendation.	

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F 514	Continued From page 11 Resident HAS elected an Advanced Directive and has defined preferences including: DO NOT RESUSCITATE (DNR). Approach: A completed gold DNR form will be maintained in the clinical record. The resident's code status will be identified by: Chart will be flagged by Orders. The physician will be notified of resident and/or responsible party's decision not to follow prescribed treatment plan. Resident #6's July 2016 monthly Physician Orders signed and dated by the physician on 7/2/16 were reviewed and documented in part, as follows: ***CODE STATUS*** 6/23/16 FULL CODE On 7/6/16 at 10:35 a.m. an interview was conducted with RN #1. RN #1 was asked what was the code status for Resident #6. RN #1 pulled Resident #6's chart and turned to the July 2016 Physician Orders and stated, "She is a Full Code." RN #1 was then asked about the Resident's signed Virginia Department of Health Durable Do Not Resuscitate Order. RN #1 stated, "Oh, she is a No Code, I will get this fixed." On 7/6/16 at 1:00 p.m. RN #1 provided the surveyor with a new order by the nurse practitioner documented in part, as follows: DIRECTIVES: DNR	F 514	5) Corrective action will be completed by 8/5/16. Monitoring will be on-going based on QA Committee recommendation.	

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F 514	Continued From page 12 ADDITIONAL ORDERS: Clarification order-resident is a DNR effective 6/28/16. On 7/6/16 at 12:00 noon a resident interview was conducted with Resident #6. Resident #6 was asked what her wishes were in the case of a medical emergency. Resident #6 stated, "I just signed the DNR paper the other day, I do not want to be resuscitated." The facility policy titled "Documentation" last revised 7/08 documented impart, as follows: "Policy: Documentation in the resident medical record will follow these principles: 1. Contain an accurate, functional, clinical representation of the actual experience of the resident in the facility; *Provides sufficient information that facility knows status of resident. *Provides demonstration of functional and clinical assessment of resident needs and ability. *Provides description of change in resident status or unusual occurrence. 2. Provides evidence of results that care was provided; *Provides documentation of physician notification and response to change in resident status; provides documentation of notification to responsible party of change in resident status. *Provides evidence that care was effective or ineffective and documents change in overall plan of care to meet resident needs in an effort to improve, stabilize or minimize decline or adverse outcome." On 7/7/16 at 12:30 p.m. a pre-exit interview was	F 514		

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conducted with the Administrator, Director of Nursing, and the Clinical Support Quality Assurance Nurse where the above information was shared. The Director of Nursing was asked what would she have expected regarding Reside #6's inaccurate medical record. The Director of Nursing stated, "They should have contacted the doctor for clarification of the order immediately and then corrected the physician order sheet."

Prior to exit no further information was provided by the facility.

Cross Reference to State Tag 12VAC5-371-360 (A) (E, (4,6).

2. The June 2016 Medication Administration Record (MAR) for Resident #5 was inaccurate. Due to a transcription error on the MAR, the resident received an additional 13 doses of Cipro.

Resident #5 was admitted to the facility on 6/15/16 following a hospitalization. The resident's diagnoses from the hospital included a Urinary Tract Infection (UTI), anemia due to a gastrointestinal bleed and hypertension.

The admission MDS (Minimum Data Set) with an assessment reference date of 6/22/16 coded the resident as scoring a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had moderately impaired daily decision making skills.

The physician admission orders dated 6/15/16

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included: Keflex (an antibiotic) 500 mg one by mouth twice a day for 6 days to treat an UTI.

On 6/16/16 the facility received a fax from the Physician Assistant (PA) at an offsite clinic to discontinue the Keflex. The PA order was to discontinue the Keflex and start Cipro 500 mg twice a day for 5 days/ ten doses. The urine culture result received at the clinic on 6/16/16 evidenced a mixed culture growth of the organisms (Morganella morganii) and Enterococcus faecalis. Both of these organisms were susceptible to Cipro.

The Keflex was discontinued on the Medication Administration Record (MAR). The Cipro was incorrectly transcribed (handwritten) onto the MAR on 6/16/16 as: Cipro 500 mg 1 tab po (by mouth) for UTI. The nurse failed to include the duration date of 5 days.

Per a pharmacy email to the administrator on 7/7/16, the pharmacy had sent a communication memo in a tote on 6/16/16 requesting a stop date for the Cipro, in addition the email indicated the pharmacy had sent a total of 33 Cipro pills on that same day.

The clinical record included a pharmacy request to clarify the stop date on an electronic MAR for the Cipro entry.

The physician addressed the stop date on 6/17/16 at 11:26 a.m. The clarified order was for Cipro 500 mg one tablet by mouth twice a day for 5 days.

The clarified order was not transcribed onto the MAR. The original handwritten order was not

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corrected to include the stop date of 5 days.

The resident received the first dose of the Cipro on the evening of 6/16/16 and continued to receive it twice a day until 6/27/16.

As a result of the transcription error the resident was administered an excessive duration of the Cipro. The Cipro should have stopped on the morning of 6/21/16, instead the resident received the Cipro from 6/16/16 to 6/27/16. Instead of receiving 10 doses of Cipro, the resident received a total of 23 doses (13 unnecessary doses of Cipro.)

The nurse mentor/ household RN (Registered Nurse) on the skilled nursing unit was interviewed on 7/6/16 at 2:10 p.m. The above findings was shared. After reviewing the order and the MAR the nurse stated, "He received a lot more than the 5 days...when the order came through the stop date was not transcribed to the MAR".

The facility document titled, "Reviewing and Transcribing Physician Orders Documenting Medications and Treatments" (not dated), read in part under Procedure for Transcribing Physician Orders: "1. Review the order for clarity and completeness. If the order is not clear or complete, contact the physician giving the order an obtain clarification. Discontinue the original order and write a new order that is clear and complete. Document that the new order is a "clarification order". 2. Transcribe the new order onto the appropriate Medication or Treatment Administration record or tracking log. Write a new entry on the appropriate MAR or TAR that includes the date that the order was received, the date the order is to be implemented, and the

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F 514	Continued From page 16 complete order." On 7/7/16 at 12:45 p.m., the above findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting. An opportunity for additional information was offered at this time.	F 514		