Printed: 10/13/2016 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER	1	E CONSTRUCTION		SURVEY PLETED
		495295	i	B. WING		10)/05/2016
ł	PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE		
RIVERS	SIDE HEALTH & REH	IAB CNTR	1	VERSIDE D LE, VA 245			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCI T BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS		F 000			
	survey was conducted Corrections are requered CFR Part 483 Federequirements. The survey/report will for the census in this 162 at the time of the consisted of 25 Re (Residents #1 through reviews (Residents 483.10(b)(4) RIGHT	ollow. 180 certified bed facine survey. The surveysident reviews with 2 ugh #22) and 3 close #23- #25). TO REFUSE; FOR	10/5/16. with 42 lity was sy sample 22 current d record	F 155	The statements made plan of correction are admission to and do constitute an agreer alleged deficiencies. To remain in complifederal and state recenter has taken or actions set forth in the plan of correction. The plan of correction conterts allegation of correction conterts allegation of correction	re not an o not ment with the herein ance with all gulations, the will take the he following the following onstitutes the following	11-4-16
33-6	The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's				compliance. All alleg deficiencies cited ha will be corrected No 2016.	RECEIN	
	option, formulate an	advance directive. escription of the facil	This		F 155	OCT 25	2016
		nt advance directives			F 100	VDH/O	LC
	Based on staff inten	s not met as evidenc view and clinical reco	ord		1. The DDNF Resident #1 corrected.		11-4-16
LABORATO	RY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE	NTATIVE'S SIGN		TITLE		(X6) DATE
	tela /	///		4.1	actairded for		10-19-11

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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OLIVILOTO TOTAL DIONICE	G MEDIONID CENT	1000				OMB MC	<u> </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495295		B. WING			10/05/2016	
NAME OF PROVIDER OR SUPPLIER RIVERSIDE HEALTH & REH	IAB CNTR	2344 RI	RESS. CITY, STA VERSIDE DI LE, VA 245	RIVE		. House reconstruction and assumption of the second	
PRÉFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI TBE PRECEDED BY FULL I INTIFYING INFORMATION)		ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECT RRECTIVE ACTION SHOU ERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
(Durable Do Not Refor 1 of 25 residents The findings include The facility staff fail complete for Reside The clinical record of 10/4/16 and 10/5/16 to the facility 7/30/1 but not limited to rhanemia, hypertensic cellulitis of bilateral infection, hypothyrodisease, and complement with a complement of 15 in Section C	staff failed to ensure a suscitate) form was a (Resident #15). ed: ed to ensure the DDient #15. of Resident #15 was 6. Resident #15 was 6 with diagnoses than itis, candidiasis, an on, edema, weaknes lower extremities, uridism, peripheral vastete small bowel obstatistion minimum data with an assessment D) of 8/5/16 assesses the summary score furnities and Virginia th Durable Do Not order dated 8/1/16. In the clinical records	reviewed admitted t included xiety, s, inary tract scular ruction. a set d the c of 15 out The d read in an an an an an an an an an	F 155	 3. 4. 5. 	forms were audite corrections were r as needed.	d and made I be ring will be ee to R forms ectly. ce will	11-4-16
A. While capable	ove, check A, B, or C of making an informe has executed a writ	ed					

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Printed: 10/13/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED			
	495295		B WING		BOT TO ANNUAL PROPERTY AND AND AND ANNUAL PROPERTY AND	10/05/2016			
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS. CITY, STAT	E. ZIP CODE					
RIVERSIDE HEALTH & REHAB CNTR 2344 RIVERSIDE DRIVE DANVILLE, VA 24540									
PRÉFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	(EACH C	DER'S PLAN OF CORRECT DRRECTIVE ACTION SHOU FERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION			
decision, the patient advanced directive Authorized to Const. The patient has advanced directive. There were no chect DDNR form. The st. DDNR form had be and resident. The form the st. The form the st. The	e of making an inform it has executed a writ which appoints a "Fent on the Patient's Eas not executed a writ." cks in any of the boxe ection at the bottom en signed by the phyform was dated 8/1/1 hission physician ordersident #15's order for scitate". iewed the unit managurse #1 on 10/4/16 a bonded that she was as incomplete. The incomplete incomplete administrator and the regional registed in the incomplete incomplete incomplete incomplete. The incomplete	es on the of the risician 6. ers dated or ger t 3:55 surprised r, the stered 1:20 p.m.	F 155						
F 309 483.25 PROVIDE C SS=D HIGHEST WELL BE		R	F 309						
provide the necessa or maintain the high mental, and psycho	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 and clinical record review it was determined that the facility staff failed to			F309 1.	A Dhysisiana ard	or for			
Based on staff inter				1.	A Physicians ordedialysis was obtain Resident #18 at the of the survey.	ned for			

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If continuation sheet Page 3 of 10

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OCIVICIO I ON MICDIONIVE	A MEDICAID SERV	TOES				OMR NC) <u>. 0938-</u> 0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				E CONSTRUCT		(X3) DATE SURVEY COMPLETED	
	495295					10/0	5/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE ZIP CODE			
RIVERSIDE HEALTH & REH	IAR CNTR	į.	VERSIDE D				
WATHOUT HEVELL & MEH	IND CHAIL	1			•		
		DAIAAII	LE, VA 245	40			
PRÉFIX (EACH DEFICIENCY MUST	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			(EACH CO	ER'S PLAN OF CORREC' RRECTIVE ACTION SHOW ERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309 Continued From pa	9		F 309	0	0		
	order prior to providir			2.	Current residents		
	Residents in the sar	mple			receiving dialysis	were	
survey, Resident #1					• •		
The Findings Includ					audited to ensure		
	a 68 year old female				Physician orders	were in	
	Admitting diagnos				place for those re	sidents	
	ot limited to: hyperte				•		
	dney disease, end st	tage renal			that receive dialys		
disease, Clostridium					corrections were i	made	
	Set (MDS) was availa	able due			as indicated.		
to Resident #18's re				2	Licensed staff will be		
	at 1 p.m. the survey			3.			
	North Wing with a Rowas the Unit Manag				educated on obta	ining	,
	ported to the survey				Physician orders	for	111-16
	red dialysis on Mond				residents who atte		11-4-16
Wednesday and Fri		ay,				JIIU	
	at 1:45 p.m. the sur	vevor			dialysis.		
	#18's clinical record.			4.	New admissions t	that	
	I produced signed ph				receive dialysis w	ill ha	
	6. Review of the sig				•		
physician orders did	l not include a physic	cian order			audited by the Un		
for Resident #18 to I					Manager/Designe	e to:	
	the clinical record p				ensure that Physi	cian	
	ated 9-27-16. The Pi				•		
	"Resident is on dialy				orders are presen	it on	
	ay and Friday)." (sic)				any new dialysis		
	e Progress Notes pro				resident.		
	9/28/16, that docume			r		النبييم	
	ut to a local vendor f	OL		5.	Any noncomplian		
dialysis services.	the elipical record a				be reported to the	⊋QA	
	the clinical record p				Committee for tra	ckina	
	"Dialysis Communication Forms" dated 9/28/16, 9/30/16 and 10/3/16 that documented that					-·····3	
	ed dialysis at a local				and trending.		
vendor.	aa alalyolo at a local	Grafy 313					
	at 2:05 p.m. the sun	vevor					Three control of the
	of Nurses (DON) an						
	ce Nurse (CCN) that						
Resident #18 was re	eceiving dialysis serv	rices at a					
	- ,						

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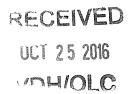
UCT 25 2016

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Printed: 10/13/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER				(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495295		B. WING		10/05/2016		
	PROVIDER OR SUPPLIER SIDE HEALTH & REH	AB CNTR	2344 RI	VERSIDE DI LE, VA 245	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL E ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECT DRRECTIVE ACTION SHOU FERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 328	surveyor notified the #18 did not have a The surveyor and C clinical record. The physician order for dialysis services/tre On October 5, 2016 met with the Admini Director of Nursing surveyor notified the that Resident #18 w treatment/services a surveyor notified the have a physician or treatment/services. No additional inform exiting the facility as to obtain a physicial dialysis services for \$483.25(k) TREATM	three times a week. e DON and CCN tha physician order for d CCN reviewed Reside e CCN was unable to Resident #18 to rece eatment. 5 at 3:45 p.m. the sur istrator (Adm), DON, (ADON) and the CC e Administrative Tear vas receiving dialysis at a local vendor. The AT that Resident #1 der to receive dialys nation was provided p is to why the facility is n order for prior to prior Resident #18.	It Resident lialysis. ent #18's local a eive rvey team Assistant N. The M (AT) see 18 did not is prior to taff failed roviding	F 309			
SS=D	proper treatment an special services: Injections; Parenteral and ente Colostomy, ureteros Tracheostomy care; Tracheal suctioning Respiratory care; Foot care; and Prostheses. This Requirement is Based on observation record review it was	stomy, or ileostomy o	ced by: d clinical		F328 1. 2.	A Physicians order obtained for Oxyge Resident # 13 at the of the survey. Current residents receiving Oxygen vaudited to ensure the Physician Orders will place for Oxygen a corrections were mas indicated.	were in endor

If continuation sheet Page 5 of 10

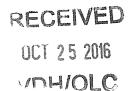


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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE	R/CLIA	(X2) MULTIPL	E CONSTRUC	TION	(X3) DATE SUR	
AND PLAN OF CORRECTION	RECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETE	
	495295		B. WING			10/05/2016	
NAME OF PROVIDER OR SUPPLIER	A STAN AND C. STANGER STANGE	I	RESS, CITY, ST.		=		
RIVERSIDE HEALTH & REH	AB CNIR	}	IVERSIDE D .LE, VA 245				
O.W. D. C.	ATTILITY OF OFFICE	<u> </u>					
PRÉFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	(EACH C	IDER'S PLAN OF CORRECT ORRECTIVE ACTION SHOU FERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 328 Continued From pa	ige 5		F 328				
	1 of 25 Residents in	the		3.	Licensed Staff were	е	
sample survey, Res					educated on ensur	ing	
The Findings Includ					that Physician orde	ers are	
	i 99 year old female on 2/1/16 and readm				present for any res		
	diagnoses included,				1		
	tension, atrial fibrilla				receiving Oxygen.		11-4-16
	onic kidney disease,	and a		4.	Unit Managers/Des	signee	11/4
pleural effusion.					will monitor new		
	inimum Data Set (M I in the clinical record				admissions to ensu	ıre	
	essment with an Ass				that Physician orde	ers for	
	RD) of 8/30/16. The				Oxygen are in place		
staff coded that Res	sident #13 had a Coo	gnitivé			• • • •		
	The facility staff				any new resident		
	t #13 required set up				receiving Oxygen.		
	vities of Daily Living Il Treatments, Proce			5.	Any noncompliance	e will	
	acility staff coded that				be reported to the	QA	
	ed oxygen therapy v				Committee for trac		ł
past 14 days.					and trending.		
	at 2:40 p.m. the sur				and donaing.		
	#13 sitting on the sid observed an oxygen						
	right hand side of th						
	at 2:55 p.m. the sur						
reviewed Resident #	13's clinical record.	Review					
of the clinical record	produced signed pl	nysician					1
	6. Review of the sign						
for Resident #13 to	not include a physic	ian order					
	at 7:20 a.m. the sur	vevor					
	#13 in bed. Residen						
	eyor observed that R						
•	liters of oxygen via	a nasal					
cannula.	at 7:25 a th	1401105					
went into Resident #	at 7:25 a.m. the sur						
	RN (#2). Resident						
	2 liters per minute vi						· ·
							1

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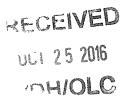


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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		495295		B. WING			10/05/2016
RIVERSIDE HEALTH & REHAB CNTR 2344 RI				RESS, CITY, STA VERSIDE DI LE, VA 2454	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID . PREFIX TAG	(EACH CC	DER'S PLAN OF CORRECT DRRECTIVE ACTION SHOU ERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 328 F 502 SS=D	cannula. On October 5, 2016 notified the Unit Ma Registered Nurse (I observed that Resid at 2 liters per minute UM (RN #1) that Re physician order to re and UM (RN #1) rev record. The UM (R physician order for loxygen. On October 5, 2016 met with the Admini Nursing DON and th Nurse (CCN). The Administrative Team receiving oxygen at surveyor notified the have a physician or No additional inform exiting the facility as to obtain a physician oxygen for Resident 483.75(j)(1) ADMINI	S at 8:25 a.m. the sur nager (UM), who wa RN #1), that the survient #13 was receiving the the surveyor notices and the surveyor notices are the surveyor. The viewed Resident #13 N #1) was unable to Resident #13 to receive the Corporate Complistrator (Adm), Direct the Corporate Complistrator (AT) that Resident #1 der to receive oxygenation was provided partion was provided partions.	es a reyor had reyor results clinical results cl	F 328	F502		
	services to meet the	The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.					
	Based on staff interview, the facility st	s not met as evidence view and clinical reco caff failed to obtain a ry test for 1 of 25 res	ord physician		1.	The Physician fo Resident # 8 was notified of the mis CBC for 9/23/16.	1-4-16

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1	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/DEPLAY (X1) PROVIDER/SUPPLIER/SUPP			1	E CONSTRUCT		(X3) DATE S	
***************************************		495295		B WING			10/05/2016	
RIVERSIDE HEALTH & REHAB CNTR 2344 R				ESS, CITY, ST /ERSIDE C LE, VA 24				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	(EACH CC	DER'S PLAN OF CORRECT DRRECTIVE ACTION SHOU FERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	laboratory tests CB test for Resident #8 Resident #8 was ac with diagnoses that anxiety, end stage r reflux disorder, ane diabetes. A review of Resident on the most recent an assessment refer facility staff assessed and to be understood a cognitive summar. On 10/5/16, a review record revealed that order for a CBC weet through September. A review of the laborational record reveal aboratory test. On 10/5/16 at 1:15 properties of the laboratory test.	ed to obtain physicial C (complete blood of a complete blood present #8's clinical record minimum data set (Note the resident to under the was assessed by score of 11. We of Resident #8's class the physician had good below the physician had good below the complete blood of the complete said she would check the said she would check the surveyor the last the administrator, director of consultant were informed that the administrator is a complete blood of the surveyor the last the administrator in the administrator	sunt) lab 8/11/16 ted to ageal sure, and revealed fIDS) with 6, the derstand I to have inical liven an 26 ident #8's 9/23/16 urses the eck the nurses med of gional b was not	F 502	-	Current residents orders will be auditensure that Labs wo obtained according Physician orders a corrections will be as indicated. Licensed Staff will educated on follow Physicians orders labs test that are ordered. Unit Manager/Deswill review the Ordered Listing report and that there is a lab for each lab order Any noncompliant be reported to the Committee for tradand trending.	ted to were g to and made be wing for signee der verify result ed. ce will	1-4-16

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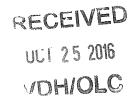
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	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1	E CONSTRUCT		(X3) DATE SURVEY COMPLETED	
ndonostatoro y appendenta		495295		B. WING		***************************************	10/05/20	016
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS. CITY, ST.	ATE, ZIP CODE			
RIVERS	IDE HEALTH & REH	IAB CNTR	2344 RI	VERSIDE D	RIVE			
			DANVIL	LE, VA 245	40			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE TBE PRECEDED BY FULL R (NTIFYING INFORMATION)	-	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECT PRRECTIVE ACTION SHOU ERENCED TO THE APPRI DEFICIENCY)	JLD BE CO	(X5) DMPLETION DATE
F 504	Continued From pa	age 8		F 504				
SS=E	ORDERED BY PHY	YSICIAN						
		ovide or obtain labora ordered by the attend						
	Based on staff inter review, the facility s	is not met as evidenc view and clinical reco taff failed to obtain a ling laboratory tests for #9).	ord physician		F504	The Dhysician fo	_	
	The findings include	•			1.	The Physician for resident # 9 was referred to the laboratory to	notified	
	prior to obtaining late. The facility staff obta 5/18/16 and 5/23/16	ed to obtain a physici boratory tests for Res ained a Dilantin level and a BMP (basic m ithout physician orde	sident #9. on netabolic			performed on 5/18 5/23/16 and 6/27/ during the Survey Period.	3/16, 16	11-4-16
	10/5/16. Resident # 6/5/12 and readmitte that included but no diabetes mellitus typinfection, hypertens hyperlipidemia, gast	of Resident #9 was re #9 was admitted to the ed 8/19/16 with diagnous t limited to new onsel to 2, sepsis, urinary to tion, psychosis, troesophageal reflux ons, depression, and	e facility noses t tract disease,			Current residents orders will be aud ensure that Labs obtained accordin Physician orders corrections will be as indicated.	lited to were ng to and e made	
	assessment with an (ARD) of 8/25/16 as cognitive summary s Section C Summary	erly minimum data se assessment reference sessed the resident viscore of 10 out of 15 Score. Yed the laboratory section 10/5/16. The laboratory	ce date with a in ction of		3.	Licensed Staff will educated on follow Physicians orders labs test that are ordered.	wing	

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section contained laboratory results for Dilantin

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OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING _ COMPLETED 495295 B. WING 10/05/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **RIVERSIDE HEALTH & REHAB CNTR** 2344 RIVERSIDE DRIVE DANVILLE, VA 24540 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION CROSS-REFERENCED TO THE APPROPRIATE DATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 504 Continued From page 9 F 504 4. Unit Manager/Designee levels obtained 5/18/16 and 5/23/16 and a BMP obtained 6/27/16. The surveyor was unable to will review the Order locate a physician order for the laboratory results. Listing report and verify that there is a lab result The surveyor informed the unit manager licensed practical nurse #1 of the above and requested for each lab ordered. assistance to locate the physician orders on 5. Any noncompliance will 10/5/16 at 8:50 a.m. be reported to the QA The surveyor informed the administrator, the Committee for tracking director of nursing, and the regional nurse and trending. consultant of the above failure to locate a physician order for the laboratory tests on 10/5/16 at 1:20 p.m. and again at 3:45 p.m. The unit manager L.P.N. #1 stated she was unable to locate the physician orders for the aforementioned laboratory tests. No further information was provided prior to the exit conference on 10/5/16.



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