STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION & HEALTHCARE CENTER LLC	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/29/17 through 6/31/17. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 145 at the time of the survey. The survey sample consisted of 22 current Resident reviews (Residents 1 through 22) and 3 closed record reviews (Residents 23 through 25).	F 000		
F 252 SS=D	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 252	Preparation and submission of this plan of correction by **Rocky Mount Rehabilitation and Healthcare, LLC,** does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. F 252 1. The Theater bathroom was thoroughly cleaned and the odors were elimated on 06/28/17 by the housekeeping staff. 2. An audit was completed by Housekeeper Director on 07/20/17 to ensure resident rooms and bathrooms are clean and odor free. 3. Housekeeping staff were re-educated by Licensued Nurse/Administrator in Training on 07/20/17 related to the requirements of maintaining a clean comfortable environment for the residents.	

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

Admin 7/24/17

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 252	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a clean comfortable homelike environment in the theatre room bathroom. The findings included. The bathroom used by the Residents of the facility in the theatre room had a pervasive odor of urine. On 06/27/17 at approximately 4:50 p.m. the surveyor entered the bathroom in the theatre room. This bathroom was noted to have a strong odor of urine. The floor of the room was covered with carpet. The commode had been flushed. Upon exiting this room the surveyor observed RN (registered nurse) #1 in the hallway and asked if the Residents of the facility used this bathroom to which RN #1 replied yes. On 06/28/17 at approximately 8:25 a.m. the surveyor again checked this room and again observed it to have a strong urine odor. The Residents of the facility declined a group interview with the surveyors. The administrative staff of the facility was notified of the odor during a meeting with the survey team on 06/28/17 at approximately 3:25 p.m. No further information regarding this issue was provided to the survey team prior to the exit	F 252	4. An audit will be completed by Housekeeping Director weekly for 4 weeks and monthly for 2 months to ensure the residents rooms and bathrooms continue to be maintained in a clean and odor free. A report will be submitted to the QA Committee monthy for 3 months. The Administrator in responsible for monitoring and follow-up. Date of compliance:	07/29/17

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F 252	Continued From page 2 conference.	F 252		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct	F 272	F 272 1. Resident #7's Comprehensive MDS with ARD of 07/29/16 section V was updated by the MDS nurse by 7/28/17 to include the date and the location of the CAA information as required. Resident #8's Comprehensive MDS with ARD of 05/30/17 section V was update by the MDS nurse by 7/28/17 to include the date and location of the CAA information as required. Resident #13's Comprehensive MDS with ARD of 11/25/16 section V was updted by the MDS nurse by 7/28/17 to include the date and location of the CAA information as required. Resident #3's Comprehensive MDS with ARD of 04/21/17 section V was updated by the MDS nurse by by 7/28/17 to include the date and location of the CAA information as required. Resident #9's Comprehensive MDS with ARD of 09/26/16 section V was updated by the MDS nurse by 7/28/17 to include the date and location of the CAA information as required.	

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F 272	Continued From page 3 observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure accurate MDS (minimum data set) assessments for 6 of 24 Residents, Residents #7, #8, #13, #3, #9, and #14. The findings included. 1. For Resident #7, the facility staff failed to identify the location where the CAA information could be found in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/29/16. The record review revealed that Resident #7 had been admitted to the facility 08/27/15. Diagnoses included, but were not limited to, mild intellectual disabilities, polyneuropathy, low back pain, dysphagia, anxiety, and chronic obstructive pulmonary disease. Section C (cognitive patterns) of this assessment included a BIMS (brief interview for mental status) summary score of 14 out of a possible 15 points.	F 272	Resident #14's Comprehensive MDS with ARD of 05/14/17 section V was updated by the MDS nurse by 07/28/17 to include the date and location of the CAA information as required. 2. An audit was completed by the Licensed Nurse/Administrator in Trainig and MDS Nurse on 07/07/17 of current residents' last Comprehensive MDS Assessment to ensure section V has been completed to include the date and location of the CAA information as required. 3. MDS Coordinator was reeducated by the Administrator on 07/07/17 and Clinical Reimbursement Specialist by 07/21/17 related to ensuring that section V of the MDS is completed to include the date and the location of the CAA information. 4. Clinical Reimbursement Specialist will audit 2 Comprehensive Assessments weekly for 4 weeks and monthly for 2 months to ensure the V section of the MDS continues to be completed to include the date and the location of the CAA information. The Administrator or Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3	

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F 272	Continued From page 4 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..." The column labeled "Location and Date of CAA documentation" contained no documentation to indicate where this information could be found. This assessment was coded to indicate the Resident had triggered for the areas of delirium, activities of daily living, falls, nutrition, and pressure. When reviewing the CAA WS (worksheets) the surveyor was unable to locate any documentation to indicate where this information could be found. The administrative team was made aware of the missing CAA information during a meeting with the survey team on 06/28/17 at approximately 3:25 p.m. No further information regarding the missing MDS information was provided to the survey team prior to the exit conference. 2. For Resident #8, the facility staff failed to identify the location where the CAA information could be found in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/30/17. The record review revealed that Resident #8 had been admitted to the facility 06/22/15. Diagnoses included, but were not limited to, atrial fibrillation, syncope and collapse, essential hypertension, and anxiety.	F 272	months. The Director of Nursing is responsible for monitoring and follow up. Date of Compliance:	07/29/17

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F 272	Continued From page 5	F 272		

Section C (cognitive patterns) of this assessment included a BIMS (brief interview for mental status) summary score of 7 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..."

For the areas of cognitive loss/dementia and visual function the column labeled "Location and Date of CAA documentation" only included the following documentation "CAA WS (worksheets) dated 6/8/2017." The actual location(s) regarding the documentation had not been documented.

When reviewing the CAA WS the surveyor was unable to locate any documentation to indicate where this information could be found.

The administrative team was made aware of the missing CAA information during a meeting with the survey team on 06/28/17 at approximately 3:25 p.m.

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

3. For Resident #13, the facility staff failed to identify the location where the CAA information could be found in section V (care area assessment (CAA) summary) of the Residents initial MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/25/16.

The record review revealed that Resident #13

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F 272	Continued From page 6 had been admitted to the facility 11/15/16. Diagnoses included, but were not limited to, hypertension, diabetes, osteoarthritis, depressive disorder, edema, and cognitive communication deficit. Section C (cognitive patterns) of this assessment included a BIMS (brief interview for mental status) summary score of 15 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..." For the areas of cognitive loss/dementia, visual function, activities of daily living, urinary incontinence, falls, nutritional status, pressure ulcer, and psychotropic drug use the column labeled "Location and Date of CAA documentation" the facility staff had documented "CAA WS (worksheets) dated 11/28/16." The actual location(s) regarding the documentation had not been documented. When reviewing the CAA WS the surveyor was unable to locate any documentation to indicate where this information could be found. The administrative team was made aware of the missing CAA information during a meeting with the survey team on 06/28/17 at approximately 3:25 p.m. No further information regarding the missing MDS information was provided to the survey team prior to the exit conference. 4. The facility staff failed to ensure Section V	F 272		

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F 272	Continued From page 7 Care Area Assessment (CAA) included dates and location where information to support the triggered items could be located for Resident #3. The clinical record of Resident #3 was reviewed 6/27/17 and 6/28/17. Resident #3 was admitted to the facility 4/7/16 with diagnoses that included but not limited to cerebral palsy, diabetes mellitus, hypertension, iron deficiency anemia, hyperlipidemia, insomnia, constipation, contracture left elbow, pain, and scoliosis. The clinical record of Resident #3 contained an annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/21/17. Resident #3 was coded with a cognitive summary score of 15 out of 15. Section V, Care Area Assessment (CAA) Summary, was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plans for ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, and Pressure Ulcer. The only documentation for ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, and Pressure Ulcer was "CAA (care area assessment) WS (worksheet) dated 5/2/17." The surveyor reviewed the CAA worksheets for each of the triggered items in Section V. The only information provided on the worksheet read "Location of Doc: CAA WS dated 5/2/2017." On the pressure ulcer worksheet was written "skin care after each episode" and "no skin breakdown noted." The nutrition status worksheet read "no changes in appetite at this time feeds self without problems."	F 272		

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F 272	Continued From page 8 The surveyor interviewed licensed practical nurse #5 on 6/29/17 at 8:30 a.m. L.P.N. #5 stated she was new to the position and realized that more information was needed on the worksheet that what she had provided. The administrative staff was informed of the findings during a meeting on 6/29/17 at 11:20 a.m. No further information was provided prior to the exit conference on 6/29/17. 5. The facility staff failed to ensure a complete Minimum Data Set (MDS) for Resident #9. Resident #9 was admitted to the facility on 3/27/16 with diagnoses of seizure disorder, depression, psychosis, PTSD, stroke, anxiety, and dementia with alcohol abuse. The annual MDS with a reference date of 9/26/16 assessed the resident with a cognitive score of "6" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for dressing, toileting, bathing , and hygiene. Section "V" for Care Area assessment (CAA) Summary was reviewed on the annual MDS. The CAA area was blank for location and date of CAA documentation. The CAA work sheet for each area triggered for care planning contained an "N/A" for location of documentation. The MDS coordinator was asked on 6/28/17 at 9:00 a.m. about the missing documentation. She stated she was new and was not the person who completed that MDS. The person completing the MDS was no longer employed by the facility.	F 272		

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F 272	Continued From page 9 The administrator, director of nursing, assistant administrator, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 6/28/17 at 3:30 p.m. 6. The facility staff failed to document the dates of when the documentation could be found in Resident #14's clinical record for Section V of the Care Area assessment (CAA) Summary of the Minimum Data Set (MDS). Resident #14 was ad mitted to the facility 5/2/16 with the following diagnoses of, but not limited to dementia, failure to thrive, high blood pressure, arthritis, manic depression, end stage renal disease, pain and renal insufficiency. On the quarterly review on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/14/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #14 was also codes as being totally dependent on one staff member for dressing, personal care, and bathing. The surveyor conducted a clinical record review on 6/27 and 6/28/17 for Resident #14. It was noted by the surveyor that on the significant change MDS with an ARD of 11/16/16 in Section V of the CAA Summary the dates and locations of the documentation to support the triggered area for the following were not properly documented: Cognitive Loss/Dementia, Visual Function, Communication, ADL Function/Rehabilitation Potential, Urinary Incontinence, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Dental Care, Pressure Ulcer, and Psychotropic Drug Use. In the Section titled "Location and dates of CAA (Care Area Assessment)	F 272		

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F 272	Continued From page 10 documentation the following was documented for each of the above mentioned areas: "CAA WS (Worksheet) 11/29/16". The surveyor reviewed the CAA Worksheets and no dates or locations were documented in that area. The surveyor interviewed Licensed Practical Nurse (LPN) #1 on 6/28/17 at 10:30 am in the conference room. LPN #1 was shown the above documented findings and stated "The dates aren't listed in the CAA Summaries like they are supposed to be. That nurse no longer works here." The administrative team was notified of the above documented findings by the surveyor on 6/28/17 at 3:30 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 6/29/17.	F 272	F278 Resident #1's Significant change MDS with ARD of 02/07/17 and Quarterly MDS with ARD of 05/08/17 was updated with the current diagnosis was completed by the MDS nurse by 07/07/17. 2. An audit was completed by the Clinical Reimbursement Specialist on 07/07/17 of the current residents' last Comprehensive and Quarterly MDS Assessment to ensure current diagnosis are included in the assessment.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	3. MDS Coordinator will be reeducated by the Administiator by 07/07/17 related to the requirements of including current diagnosis in the MDS assessments. 4. Clinical Reimbursement Specialist will audit 2 Comprehensive Assessments weekly for 4 weeks and monthly for 2 months to ensure current resident diagnosis continue to be included on the MDS assessments. The Administrator or Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months.	

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F 278	Continued From page 11 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure accurate minimum data set (MDS) assessments for 1 of 24 residents (Resident #1). The findings included: The facility staff failed to code Resident #1's active diagnosis of neurogenic bladder on the significant change in MDS with an assessment reference date (ARD) of 2/7/17 and the quarterly MDS with an ARD of 5/8/17. The clinical record of Resident #1 was reviewed 6/28/17 and 6/29/17. Resident #1 was admitted to the facility 4/14/16 and readmitted 1/10/17 with diagnoses that included but not limited to urine retention, urinary tract infection, hypertension, sepsis due to methicillin resistant staphylococcus	F 278	The Director of Nursing is responsible for monitoring and follow up. Date of Compliance:	07/29/17

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aureus, altered mental status, hypokalemia, bilateral femoral neck fractures, hyperlipidemia, chronic pain, and chronic hepatitis. The quarterly MDS with an ARD of 5/8/17 assessed the resident with a cognitive summary score of 12 out of 15 in Section C Cognitive Summary.

Resident #1's January 2017 readmission orders included to change Foley catheter monthly using 16 Fr (French), 30 cc (cubic centimeter) catheter on the 23rd of each month, starting 1/23/17. Diagnosis Other Retention of Urine (R33.8). Record reviewed revealed the Foley catheter had been changed each month on the 23rd from January through June 2017.

The surveyor reviewed the significant change in MDS with an ARD of 2/7/17. Section H. Bladder and Bowel was marked for an indwelling catheter and urinary continence was coded as a "9"-not rated, resident had a catheter. Section I Active Diagnoses was not coded to include Resident #1's genitourinary status. All four of the options were unchecked-I1400 (Benign Prostatic Hypertrophy), I1500 (Renal Insufficiency), I1550 (Neurogenic Bladder), and I1650 (Obstructive Uropathy). Additional active diagnoses I8000 did not include urine retention. The quarterly MDS with an ARD of 5/8/17 was reviewed. Section H. Bladder and Bowel was marked for an indwelling catheter and urinary continence was coded as a "9"-not rated, resident had a catheter. Section I Active Diagnoses was not coded to include Resident #1's genitourinary status. The two options were I1500 neurogenic bladder and I1650 obstructive uropathy. Neither were marked. Additional active diagnoses did not include urine retention.

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F 278	Continued From page 13 The surveyor interviewed the MDS registered nurse #1 on 6/29/17 at 8:30 a.m. R.N. #1 stated she was new to the position and had missed the diagnoses on the quarterly MDS. The significant change MDS was done by the previous MDS staff she stated. The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator in training of the above concern during the conference meeting on 6/29/17 at 11:20 a.m. No further information was provided prior to the exit on 6/29/17.	F 278		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	F 309	F 309 1. Resident #1's physician was notified on 07/19/17 by Unit Manager related to the holes in the MAR documentation for prescribed meds indentified and missing documentation for Intake and output with no new orders noted. Resident #1 was re-assessed and a pain evaluation completed by the licensed nurse on 07/20/17 with no change in condition noted. Resident # 3's physician was notified by Unit Manger on 07/19/17 related to missing documentation for blood sugars with no new orders noted. Resident #3 was re-assessed by the licensed nurse on 07/20/17 with no change in condition noted. Resident # 4's physician was notified by Unit Manger on 07/19/17 related to missing documentation for blood sugars with no new orders noted. Resident #4 was re-assessed by the licensed nurse on 07/20/17 with no change in condition noted. Resident # 8's physician was notified by Unit manger on 07/19/17 related to	

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F 309	Continued From page 14 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for 7 of 24 residents (Resident #1, Resident #3, Resident #4, Resident #8, Resident #15, Resident #11, and Resident #12). The findings included: 1. The facility staff failed to administer medications as ordered by the physician and failed to obtain I&Os (intake/output) for Resident #1. The clinical record of Resident #1 was reviewed 6/28/17 and 6/29/17. Resident #1 was admitted to the facility 4/14/16 and readmitted 1/10/17 with diagnoses that included but not limited to urine retention, urinary tract infection, hypertension, sepsis due to methicillin resistant staphylococcus aureus, altered mental status, hypokalemia,	F 309	missing documentation for blood sugars with no new orders noted. Resident #8 was re-assessed by the licensed nurse on 07/20/17 with no change in condition noted. Resident # 15's physician was notified by Unit Manger on 07/19/17 related to the medication error with clarification orders noted. Resident #14 was re-assessed by the licensed nurse on 07/20/17 with no change in condition noted. Resident # 11's physician was notified by Unit Manger on 07/19/17 related to missing assessment documentation post dialysis with no new orders noted. Resident #11 was re-assessed by the licensed nurse on 07/20/17 with no change in condition noted. Resident # 12's physician was notified by Unit Manger on 07/19/17 related to the medication error with clarification orders noted. Resident #12 was re-assessed by the licensed nurse on 07/20/17 with no change in condition noted. 2. Unit managers will complete an audit of the current residents' MARS and intake/output documentation to	

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F 309	Continued From page 15 bilateral femoral neck fractures, hyperlipidemia, chronic pain, and chronic hepatitis. The quarterly MDS with an ARD of 5/8/17 assessed the resident with a cognitive summary score of 12 out of 15 in Section C Cognitive Summary. Resident #1's current comprehensive care plan dated 1/24/17 and revised 6/23/17 identified the focus area for alteration in elimination. Interventions: Intake and output of ordered. Resident #1's care also included a plan for alteration in comfort. Interventions: Administer medications as ordered. (a) The May 2017 physician's orders read "5/25/17 Keflex 500 mg (milligrams) every 8 hours for cellulitis until 6/1/17." A review of the May 2017 electronic medication record (eMAR) revealed no documentation that Keflex 500 mg was administered on 5/27/17 at 1400 (2:00 p.m.). The surveyor informed the director of nursing of the concern on 6/28/17 at 4:00 p.m. The DON stated "I see the holes." (b). The May 2017 and June 2017 physician's orders read "OxyContin tablet ER (extended release) 12 Hour Abuse-Deterrent 10 mg Give 1 tablet by mouth three times a day related to other Chronic Pain (G89.29). On hold from 06/01/2017 05:17 to 06/02/2017 05:15." A review of the May 2017 eMAR revealed no documentation that OxyContin ER had been administered on 5/27/17 at 1400 (2:00 p.m.). A review of the June 2017 eMAR revealed no evidence that OxyContin had been administered on 6/21/17 at 2200 (10:00 p.m.). The entry boxes for documentation that medications had been administered were blank. The surveyor informed the director of nursing on 6/28/17 at 4:00 p.m. of the above concern. The	F 309	ensure medications are administered, blood sugars is monitored and Intake/Output is obtained and documented per physician's orders. An audit was completed on 07/07/17 by Unit Mangers to ensure post dialysis assessments audit complted on 07/12/17 by Unit Manager are completed and documented as required. 3. Licensed nurses will be re-educated by the Assistant Director of Nursing or Director of Nursing by 07/07/17 related to the requirement of administering medication, obtaining blood sugars levels and obtaining intake/output per physician's orders including documentation requirements. License Nurses were re-educated on 07/09/17 by Unit Manager related to the requirements of completing post dialysis assessments including documentation requirements. 4. Unit managers will complete audits weekly for 4 weeks and	

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F 309	Continued From page 16 DON stated "I see the holes." The surveyor requested the narcotic sheet for 5/27/17 and 6/21/17. No further information was provided. (c). The May 2017 physician's order read in part "Intake and Output every shift Order date 1/24/17 Start date 1/24/17." The May 2017 eMAR revealed no evidence Resident #1's intake and output was completed. There was no intake and output for the following days/shifts: Day shift: 5/1/17, 5/6/17, 5/7/17, 5/21/17 and 5/26/17. No intake and output obtained on 11-7 shift on 5/27/17. The June 2017 physician's orders also had orders for Intake and Output every shift. The June 2017 eMAR had no evidence I&O was done on the following days/shifts: Day shift: 6/4/17, 6/10/17, 6/20/17, 6/25/17 and 6/27/17; 3-11 shift: 6/7/17; and 11-7 shift 6/25/17. The surveyor informed the director of nursing of the above concern on 6/28/17 at 4:00 p.m. The DON stated "I see the holes." No further information was provided prior to the exit conference on 6/29/17. 2. The facility staff failed to obtain blood sugars as ordered by the physician for Resident #3. The clinical record of Resident #3 was reviewed 6/27/17 and 6/28/17. Resident #3 was admitted to the facility 4/7/16 with diagnoses that included but not limited to cerebral palsy, diabetes mellitus, hypertension, iron deficiency anemia, hyperlipidemia, insomnia, constipation, contracture left elbow, pain, and scoliosis.	F 309	monthly for 2 months to ensure medications continue to be administered, blood sugars are obtained and documented per physician's orders and intake/output continues to be obtained and documented per physican's orders and post dialysis assessments continue to be completed as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion date:	07/29/17

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The clinical record of Resident #3 contained an annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/21/17. Resident #3 was coded with a cognitive summary score of 15 out of 15.

Resident #3's current comprehensive care plan dated 1/16/17 and revised 5/2/17 was reviewed 6/28/17 and included the focus of area of nutrition. Interventions: Administer medications as ordered. Blood sugar per order.

Resident #3's signed April 2017 physician orders included the following: Accuchecks TID (three times a day) before meals related to Diabetes Mellitus due to underlying condition with other specified complication (E08.69): Diabetes Mellitus due to underlying condition (E08)."

The surveyor reviewed the June 2017 electronic medication administration record (eMAR). The entry read "Accuchecks tid before meals related to Diabetes Mellitus due to underlying condition with other specified complication (E08.69); Diabetes Mellitus due to underlying condition (E08)-Order date-01/16/17 1413."

The 6/7/17 1130 a.m. blood sugar entry was blank. A review of the June 2017 progress notes for 6/7/17 was done. There were no progress notes written 6/7/17. The surveyor informed the administrator in training of the above concern on 6/28/17 at 4:30 p.m.

The surveyor informed the administrative staff of the above concern in the conference summary on 6/29/17 at 11:20 a.m.

No further information was provided prior to the

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F 309	Continued From page 18 exit conference on 6/29/17. 3. The facility staff failed to obtain blood sugars as ordered by the physician for Resident #4. The clinical record of Resident #4 was reviewed 6/27/17 and 6/28/17. Resident #4 was admitted to the facility 4/28/11 and readmitted 10/17/16 with diagnoses that included but not limited to multiple sclerosis, paraplegia, bacterial infection, depressive disorder, hypotension, chronic pain, urinary tract infection, anemia, demyelinating disease, and type 2 Diabetes Mellitus. Resident #4's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/12/17 assessed the resident with a BIMS (brief interview for mental status) score as 15 out of 15. Resident #4's current comprehensive care plan dated 1/17/17 and revised 5/31/17 identified the focus area of nutrition and interventions included blood sugar as ordered. A telephone order dated 6/5/17 read "Check finger glucose daily x 5 days for review." The surveyor reviewed the June 2017 electronic medication administration record on 6/27/17. The entry read "Blood sugar daily for 5 days for monitoring in the morning until 06/10/2017 06:30 -Order date-06/05/2017 1035." The June 2017 eMAR revealed the results of blood sugars obtained for 4 days on 6/6/17, 6/7/17, 6/8/17 and 6/9/17-four (4) blood sugars were obtained not for 5 days as ordered by the physician. The surveyor reviewed the progress notes from 6/5/17 through 6/10/17. There were	F 309		

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F 309	Continued From page 19 no recorded blood sugar results in the progress notes. The surveyor informed licensed practical nurse #4 on 6/27/17 at 3:40 p.m. of the above concern. L.P.N. #4 stated the blood sugars should be recorded on the eMAR or maybe in the progress notes. L.P.N. #4 stated "It looks like they were only done for 4 days." The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator in training of the above concern on 6/28/17 at 3:25 p.m. No further information was provided prior to the exit conference on 6/29/17. 4. For Resident #8, the facility staff failed to obtain the Residents blood sugars as ordered by the physician. The record review revealed that Resident #8 had been admitted to the facility 06/22/15. Diagnoses included, but were not limited to, diabetes, atrial fibrillation, syncope and collapse, essential hypertension, and anxiety. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/30/17 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points. Section I (active diagnoses) included diabetes. The clinical record included a physicians order to obtain a blood sugar in the mornings due to diabetes. The order date was documented as 02/16/17. On 02/22/17 the physician changed the order to check glucose once weekly on Thursday.	F 309		

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When reviewing the Residents clinical record for the month of June 2017 the surveyor was only able to find blood sugars for 06/01, 06/02, 06/03, 06/06, 06/13, 06/15, and 06/17.

The administrative team was made aware of the missing blood sugars during a meeting with the survey team on 06/28/17 at approximately 3:25 p.m.

On 06/29/17 at approximately 2:20 p.m. LPN (licensed practical nurse) #1 verbalized to the surveyor that they were unable to locate any further information regarding this Resident.

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

5. The facility staff failed to correctly administer the prescribed dose of medication by the physician for Resident #14.

Resident #14 was readmitted to the facility on 5/11/15 with the following diagnoses of, but not limited to ulcerative colitis, malnutrition, anxiety disorder, depression, chronic pain, and retention of urine. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/8/17 scored the resident as having a BIMS (Brief Interview for Mental Interview) score of 15 out of a possible score of 15. Resident #14 was also coded as requiring extensive assistance of one staff member for dressing and bathing.

A clinical record review was performed and a medication pass and pour observation was made by the surveyor on 6/28/17 concerning Resident #14. On the medication pass and pour

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observation that was made by the surveyor on 6/28/17 at 9 am, the surveyor observed Licensed Practical Nurse (LPN) #2 to attempt to administer the following medication to the resident: "Metamucil 3.4 gms (grams) po (by mouth) BID (twice a day)". LPN #2 reviewed the order on the Resident's MAR (Medication Administration Sheet) and matched it with the label on the Metamucil bottle. LPN #2 stated to the surveyor "I'm going to call the physician and clarify this order. The physician's order and the bottle label doesn't match. Let me give the other meds (medicines) and I will call the physician."

At 10 am, LPN #2 came to the surveyor and stated "I called the doctor and clarified the order. I am going to go give the correct dose to the resident now." The surveyor went with LPN #2 to observe her administer the medication. The surveyor reviewed the clarified order that was 'Metamucil 2.4 gms po BID." LPN #2 administered this dose to Resident #2.

The surveyor reviewed the physician order sheet for June, 2017 and the order stated: "Metamucil Capsule ...Give 2.4 gram by mouth two times a day for Constipation." This order had been received by the facility on 4/4/17 according to the documentation on the physician order sheet dated 4/28/17. The physician signed the order sheet on 5/3/17 according to this order sheet. The surveyor reviewed the resident's MAR from the date of 4/14/17 until present date of 6/28/17 and the nurses had initialed the MAR for the following medication was given as: "Metamucil 3.4 gram by mouth two times a day for Constipation" from 4/14/17 until LPN #2 caught the error and clarified the order on 6/28/17 with the physician.

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At 11 am, the director of nursing (DON) was notified of the above documented findings concerning the medication pass and pour observation made on this day as documented above. The surveyor requested a copy of the facility's policy on medication administration.

At 11:20 am, the surveyor received a copy of the facilities policy titled "...Dose Preparation and Medication Administration" which stated in section 4.1.1 "Verify each time a medication is administered that it is the correct medication, at the correct dose ..."

The administrative team was notified of the above documented findings on 6/28/17 at 3:30 pm in the conference room by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 6/29/17.

6. The facility staff failed to maintain complete dialysis communication for Resident #11.

Resident #11 was readmitted to the facility on 1/23/16 with the following diagnose of, but not limited to high blood pressure, diabetes, depression, end stage renal disease, and Bipolar Disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/9/17 the resident was coded as requiring extensive assistance from one staff member for dressing and bathing. Resident #11 had a BIMS (Brief Interview for Mental Interview) score of 15 out of a possible score of 15 on this MDS.

The surveyor conducted a clinical record review on Resident #11's clinical record on 6/27/17 and

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noted the resident received dialysis treatments at an outside facility 3 times a week but the surveyor could not locate communication documentation between the facility and the dialysis facility. The surveyor asked LPN (Licensed Practical Nurse) #3 for the dialysis communication notes for the resident on 6/27/17 at 2 pm.

The administrative team was notified on 6/28/17 at 3:30 pm of the above documented findings and of needing to review the communication sheets between the facility and the dialysis center when the resident receives dialysis by the surveyor. The director of nursing stated "____ (name of LPN #3) is getting those together for you now."

On 6/29/17 at 9 am, LPN #3 provided copies of the dialysis communications sheets for the months of May and June, 2016. On these communication sheets, the only note written by the long term care facility were post blood pressures for each of the dialysis visits that were made 3 times a week as ordered from 5/1/17 through 6/19/17. The surveyor asked if this was all the documentation that was completed and LPN #3 replied "yes it is. There is nothing in the nursing notes for these dates either about performing an assessment of the resident when he returned to the facility after each visit except for the post blood pressures."

The director of nursing (DON) was notified of the above documented interview with LPN #3. The DON stated "I know. We have looked into everything we could but they only have blood pressures documented when he returned from dialysis. There were no assessments in the nurses' notes either." The surveyor asked the DON if she would expect that a nursing

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assessment would be performed after the resident returns to the facility after each dialysis visit. The don stated "yes I do."

No further information was provided to the surveyor prior to the exit conference on 6/29/17.

7. For Resident #12 facility staff failed to administer the ordered dose of anticoagulant medication.

Resident #7 was admitted to the facility on 7/29/16 with diagnoses including deep vein thrombosis, aftercare knee replacement, hypertension, peripheral vascular disease, anxiety, and depression. On the Minimum Data Set assessment with Assessment Reference Date 6/10/17, the resident scored 11/15 on the Brief Interview for Mental Status and was assessed as without signs of delirium, psychosis, or behaviors affecting others.

During clinical record review on 6/28/17, the surveyor noted a physician visit communication note dated and signed 6/14/17. Under Significant Findings it said "Wrong dose of Eliquis 5 mg PO BID See Attached Note". Staff were unable to locate the original order or the attached note referenced.

The resident's order summary from the electronic clinical record indicated that Eliquis Tablet (Apixaban) Give 10 milligrams by mouth twice per day related to ACUTE EMBOLISM AND THROMBOSIS OF UNSPECIFIED DEEP VEINS OF UNSPECIFIED LOWER EXTREMITY was written by the prescriber on 6/3/17. The resident's order summary from the electronic clinical record indicated that Eliquis Tablet (Apixaban) Give 10 milligrams by mouth twice per day for Prophylaxis

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was a verbal order on 6/13/17. The resident's order summary from the electronic clinical record indicated that Eliquis Tablet (Apixaban) Give 5 milligrams by mouth twice per day related to ACUTE EMBOLISM AND THROMBOSIS OF UNSPECIFIED DEEP VEINS OF UNSPECIFIED LOWER EXTREMITY was written by the prescriber on 6/14/17.

The clinical record did not contain physician notes dated 6/3/17 or 6/13/17. Physician's Telephone Orders sheets in the physical clinical record contained orders written 6/5/17 and 6/6/17. No verbal telephone orders were written on 6/13/17.

The medication administration record indicated the resident received Eliquis 10 mg twice per day 6/3/17 through 6/13/13 and was held for 9=other/See progress notes on 6/14/16 at 10 AM. Nurse's notes on 6/14/17 at 2:05 PM indicated "awaiting to arrive from pharmacy MD and RP aware" and on 6/14/17 at 2:06 PM "duplicate order". The medication administration order also indicated the resident received Eliquis 10 mg by mouth two times per day from 6/13/17 at 22:00 through 6/15/17 at 10:00. Again, 6/14/17 at 10 AM was marked 9= Other/See progress notes. The medication administration record indicated the resident received Eliquis 5 milligrams twice per day from 6/15/17 at 22:00 through 6/28/17 at 10:00 with the exception of 6/21/17 at 22:00, which was blank. No nurse's note on 6/21/17 referenced administration of Eliquis.

The surveyor discussed concerns on 6/28/17 with the resident's nurse, the unit manager, and the director of nursing. None were able to locate the original orders, or to state what dose of Eliquis the resident received on 6/13, 6/14, or 6/21.

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F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 315	F 315 Resident # 1's physician was notified by Unit Manager on 07/19/17 related to the missing documentation for foley cath care. Resident #1 was re-assessed by the licensed nurse on 07/20/17 with no sign and symptoms of infection noted. 2. Unit managers will complete an audit by 07/07/17 to ensure is foley cath care is completed per plan of care as required. 3. Licensed nurses will be re-educated by the Assistant Director of Nursing or Director of Nursing by 07/20/17 related to the requirement of completing foley cath care per resident's plan of care including documentation requirements. 4. Unit managers will complete audits weekly for 4 weeks and monthly for 2 months to ensure foley cath care continue to be provided as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months.	

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F 315	Continued From page 27 Based on observation, staff interview and clinical record review, the facility staff failed to ensure Foley catheter care was provided to 1 of 24 residents (Resident #1). The findings included: The facility staff failed to provide Foley catheter care to Resident #1. The clinical record of Resident #1 was reviewed 6/28/17 and 6/29/17. Resident #1 was admitted to the facility 4/14/16 and readmitted 1/10/17 with diagnoses that included but not limited to urine retention, urinary tract infection, hypertension, sepsis due to methicillin resistant staphylococcus aureus, altered mental status, hypokalemia, bilateral femoral neck fractures, hyperlipidemia, chronic pain, and chronic hepatitis. The quarterly MDS with an ARD of 5/8/17 assessed the resident with a cognitive summary score of 12 out of 15 in Section C Cognitive Summary. The current comprehensive care plan initiated 1/24/17 and revised 6/23/17 identified the focus area of alteration in elimination: hx (history of) urine retention-indwelling Foley catheter, hx UTI (urinary tract infection). Interventions: Provide catheter care q shift (every shift). Resident #1's June 2017 physician orders included to change Foley catheter monthly using 16 Fr (French), 30 cc (cubic centimeter) catheter on the 23rd of each month, starting 1/23/17 and Foley catheter care q shift (every shift). Diagnosis Other Retention of Urine (R33.8). Record reviewed revealed the Foley catheter had been changed each month on the 23rd from January through June 2017.	F 315	The Director of Nursing will be responsible for monitoring and follow up. Date of compliance:	07/29/17

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F 315	Continued From page 28 The surveyor reviewed the May 2017 and June 2017 electronic medication administration records (eMARS). The May 2017 had no evidence catheter care was provided six (6) times in May-5/1/17, 5/6/17, 5/7/17, 5/13/17, 5/21/17 and 5/28/17 and no evidence Foley catheter care was provided three times in June-6/4/17, 6/10/17 and 6/25/17. The surveyor interviewed and showed the director of nursing the printed copies of the May and June 2017 eMARs on 6/28/17 at 4:00 p.m. The director of nursing was informed that the clinical record showed no evidence Foley catheter care was done nine (9) times in May/June 2017. The surveyor requested the facility policy on Foley catheter care on 6/28/17. No further information was provided prior to the exit on 6/29/17.	F 315	F 323 1. The 2 bottle of chemicals were removed from the shower room on 06/28/17 by Licensed Nurse/Administrator in Training. 2. An audit was completed by Maintenance staff on 07/20/17 to ensure chemicals are hazardous meterials are secured as required. 3. Nursing staff were re-educated by Director of Nursing on 07/21/17 related to locking/securing chemicals and hazardous meterials as required. Housekeeping staff were re-educated by Director of Nursing on 07/21/17 related to locking/securing chemicals and hazardous meterials as required. 4. Maintenance staff and Housekeeping staff will complete and audit weekly for 4 weeks and monthly for 2 months to ensure chemicals and hazardous material remain locked/secured as required. The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The	
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and	F 323		

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F 323	Continued From page 29 maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure hazardous chemicals were properly stored on 2 of 3 units, the east unit and 2 west. The findings included. The surveyor observed unsecured bottles of bleach germicidal cleaner in the shower rooms on the east unit and 2 west. On 06/28/17 at approximately 8:10 a.m. the surveyor entered the shower room on 2 west. The shower room included a brown cabinet with a combination lock. This cabinet was observed to be unlocked. When the surveyor opened the door they were able to observe a bottle of bleach germicidal cleaner (1 quart). The outside of this cabinet included a green sign that read please keep the doors locked at all times! Thanks. Upon exiting this shower room the surveyor observed the DON (director of nursing) in the hallway. The DON was notified of the unsecured bleach cleaner.	F 323	Administrator will be responsible for monitoring and follow up. Date of Compliance:	07/29/17

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F 323	Continued From page 30 On 06/28/17 at approximately 8:16 a.m. the surveyor entered the shower room on the east unit. This shower room was observed by the surveyor to include a brown cabinet with a combination lock. This cabinet was unlocked and contained a bottle of bleach germicidal cleaner (1 quart). Again upon exiting the shower room the DON was notified of the unsecured chemical. On 06/28/17 at approximately 3:25 p.m. the administrative staff was notified of the unsecured bleach cleaner. The MSDS (material safety data sheet) for this chemical identified it as a moderate eye irritant. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F 329	F 329 1. Resident #8 was re-assessed by the Unit manager on 7/20/17 including checking the resident's heart rate with no change in condition noted. Resident #8's physician was notified of the med error by the licensed nurse on 07/19/17 with no new orders noted. Resident # 1 was re-assessed by the licened nurse on 07/20/17 including checking the resident's heart rate, behaviors, interventions and side effects of psychoactive medication with no change in condition noted. Resident #1's physician was notified of the med error by the licensed nurse on 07/19/17 with no new orders noted. 2. An audit was completed by Unit Mangers on 07/10/17 to ensure vital signs are monitored per physician's orders as required. An audit was completed by Unit Managers on 07/10/17 to ensure behaviors, interventions and side effects for psychotropic drugs are monitored as required.	

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F 329	Continued From page 31 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure 2 of 24 Residents were free of unnecessary medications, Residents #8 and #1. The findings included. 1. For Resident #8, the facility staff failed to obtain the physician ordered heart rate prior to administering the medication atenolol. Indicating the medication was administered without following the physician ordered parameters.	F 329	3. Licensed nurses were re-educated by Administrator on 07/07/17 related to monitoring vital signs per physician's orders as well as monitoring behaviors, interventions and side effects of psychotropic medications as required. 4. Unit Managers, DON and licensed staff will complete and audit weekly for 4 weeks and monthly for 2 months to ensure nurses continue to monitor vitals signs per physician's orders; also continue to monitor behaviors, interventions and side effects for residents receiving psychotropic medications as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Date of Compliance:	07/29/17

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F 329	Continued From page 32 The record review revealed that Resident #8 had been admitted to the facility 06/22/15. Diagnoses included, but were not limited to, diabetes, atrial fibrillation, syncope and collapse, essential hypertension, and anxiety. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/30/17 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points. The clinical record included a physicians order for atenolol 25 mg 1 tab by mouth hold for heart rate less than 60. The diagnosis was listed as atrial fibrillation. A review of the clinical record revealed that the facility staff was obtaining the Residents heart rate until 06/20/17. After that date the administration blocks where the heart rate would be documented were marked with an "X." The administrative staff was notified of the missing heart rates during a meeting with the survey team on 06/28/17 at approximately 3:25 p.m. Prior to the exit conference the facility staff provided the surveyor with the heart rates for 06/21, 06/23, and 06/25/17. On 06/29/17 at approximately 9:30 a.m. LPN (Licensed practical nurse) #1 stated she was unable to find any further information regarding this Resident. No further information regarding this issue was provided to the survey team prior to the exit	F 329		

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conference.
2. The facility staff failed to obtain heart rates prior to the administration of the antihypertensive medication Metoprolol for Resident #1 and failed to monitor behaviors, interventions and side effects for the use of antidepressants (Lexapro and Trazodone).

The clinical record of Resident #1 was reviewed 6/28/17 and 6/29/17. Resident #1 was admitted to the facility 4/14/16 and readmitted 1/10/17 with diagnoses that included but not limited to urine retention, urinary tract infection, hypertension, sepsis due to methicillin resistant staphylococcus aureus, altered mental status, hypokalemia, bilateral femoral neck fractures, hyperlipidemia, chronic pain, and chronic hepatitis. The quarterly MDS with an ARD of 5/8/17 assessed the resident with a cognitive summary score of 12 out of 15 in Section C Cognitive Summary.

Resident #1's current comprehensive care plan was reviewed. One focus area identified 1/16/17 and revised 3/17/17 was self-care deficit related to at risk for constipation, full code and HTN (hypertension). Interventions: Administer medications as ordered. Resident #1's plan of care also included the focus are of potential for adverse side effects r/t (related to) use of psychotropic medications/anxiety meds, hx (history of) anxiety. Initiated 1/26/17 and revised on 1/26/17. Interventions: Administer medications as ordered. Observe for tolerance and effectiveness. Report any possible adverse side effects to MD/ARNP (Advanced Registered Nurse Practitioner). Observe for adverse side effects [mental status changes, GI (gastrointestinal), balance/gait disturbances, appetite changes]. Report any noted side effects

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to MD/ARNP. Pharmacist to review medications monthly.

(a). The June 2017 physician's orders were reviewed. Resident #1's orders included the following:
1. Metoprolol Tartrate tablet 75 mg Give 75 mg by mouth two times a day for htn (hypertension) related to Essential (Primary) Hypertension (I10) SBP (systolic blood pressure) < (less than) 110 HR (heart rate) < 60. Order date 1/31/2017. Start Date 1/31/2017.

2. Lisinopril Tablet 40 mg Give 40 mg by mouth one time a day related to Essential (Primary) Hypertension (I10) HR and B/P (blood pressure) daily. Order Date 3/16/17 Start Date 3/16/17.

3. Clonidine HCL Tablet 0.1 mg Give 0.1 mg by mouth every 12 hours as needed for Elevated Blood Pressure sbp (systolic blood pressure) > (greater than) or = 180 dbp (diastolic blood pressure) > or =100. Order date 3/16/17 Start date 3/16/17.

The surveyor reviewed the May 2017 and June 2017 electronic medication administration records (eMARs). The entry on the May 2017 and June 2017 read "Metoprolol Tartrate Tablet 75 mg by mouth two times a day for htn related to Essential (Primary) Hypertension (I10) SBP < (less than) 110 HR < 60." The eMARs for both May 2017 and June 2017 had no monitoring of Resident #1's heart rate for both administration times of 9:00 a.m. and 5:00 p.m.

The May 2017 eMAR also had an entry that read "Lisinopril Tablet 40 mg Give 40 mg by mouth one time a day related to Essential (Primary)

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Hypertension (I10) HR and B/P daily." There were no recorded heart rates or daily blood pressures recorded on the May and June 2017 eMARs with the Lisinopril entry. The Lisinopril 40 mg administration time changed on 6/13/17 from 9:00 a.m. to 10:00 a.m.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator in training of the above issue in the end of the day meeting on 6/28/17 at 3:25 p.m.

(b). The June 2017 physician's orders were reviewed. The orders included Behavior Monitoring Anti-Depression q shift (every) shift 0. None 1. Agitated 2. Depressed/Withdrawn 3. Insomnia 4. Mood Change 5. Restless 6. Uncooperative 7.____. Order date 4/26/17 Start date 4/26/17. Interventions Anti-Depressant Q Shift: 0. None 1. Redirect 2. 1 on 1 3. Activities 4. Return to Room 5. Toilet 6. Give food 7. Give fluids 8. Change position 9. Adjust room temp 10. Back rub every shift. Side effects Anti-Depressant q shift: 0. None 1. Dry mouth 2. Constipation 3. Blurred vision 4. Urinary retention 5. Orthostatic hypotension 6. Anxiety 7. Agitation 8. Appetite changes 9. HA every shift. Resident #1 was currently receiving Lexapro 5 mg (milligrams) every morning that started 4/14/17 and Trazodone 50 mg at bedtime.

The surveyor reviewed the May 2017 and June 2017 electronic medication administration records. There were no behavior monitoring, interventions or side effect assessment on these days/shifts: days: 5/1/17, 5/6/17, 5/7/17, 5/13/17, 5/21/17, and 5/28/17. There were no behavior monitoring, interventions or assessment for side

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ROCKY MOUNT REHABILITATION & HEALTHCARE CENTER LLC	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 36 effects on day shift for 6/4/17, 6/10/17, and 6/25/17. The surveyor interviewed the director of nursing on 6/28/17 at 4:00 p.m. and provided copies of the May 2017 and June 2017 eMARs. The DON stated she saw where the monitoring was not done. The surveyor informed the administrative staff of the above concern during the conference meeting on 6/29/17 at 11:20 a.m. No further information was provided prior to the exit conference on 6/29/17.	F 329		
F 333 SS=E	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 2 of 24 residents (resident #5 and #3) were free from a significant medication error. The findings include: 1. The facility staff failed to administer insulin per physician orders for Resident #5. Resident #5 was admitted to the facility on 1/26/16 with diagnoses of diabetes, atrial	F 333	F 333 1. Resident #5 was re-assessed by the licened nurse 07/20/17 including checking the resident's blood sugar with no change in condition noted. Resident #5's physician was notified of the med error by the licensed nurse on 07/19/17 with no new orders noted. Resident #3 was re-assessed by the licened nurse 07/20/17 including checking the resident's blood sugar with no change in condition noted. Resident #3's physician was notified of the med error by the licensed nurse on 07/19/17 with no new orders noted. 2. An audit was completed by Unit managers, and licened staff on 07/10/17 to ensure insulin is being administered per physician's orders as required. 3. Licensed nurses were re-educated by Administrator on 07/07/17 related to the requirements of administering medication per physician's orders including insulin orders.	

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F 333	Continued From page 37 fibrillation, coronary artery disease,congestive heart failure, hypertension, peripheral vascular disease, chronic obstructive pulmonary disease, anxiety, depression, mood disorder, and pain. The most recent significant change Minimum Data Set (MDS) with a reference date of 3/22/17 assessed the resident with a cognitive score of "14" of "15". The resident was assessed requiring total assistance of 1 person for bed mobility, transfers, dressing, toileting, bathing, and hygiene. The clinical record was reviewed. The physician ordered "to monitor blood sugars at 6 a-2p-10p three times a day related to diabetes" with an original start date of 4/13/17. The physician also ordered ,"Novolog (Insulin Aspart) inject 3 iu (units) subcutaneously every 8 hours as needed for prophylaxis related to Type 2 Diabetes Mellitus without complications- Administer if BS (blood sugar)> 200. The medication administration record (MAR) for May 2017 was reviewed. The nurses failed to administer the Noviolog insulin for a blood sugar greater than 200 at 6 am on 5/2, 5/3, 5/6, 5/16, 5/25, and 5/26. The nurses also failed to administer the Novolog insulin at 2 pm on 5/13, 5/18, 5/24, and 5/26. The 10 pm Novolog was not administered on 5/8, 5/13, 5/16, 5/23, 5/25, 5/28, and 5/30. There were no nursing notes related to the above dates that the physician was notified of the the failures to administer the medications or that the resident refused to have the insulin administered. The MAR for June 2017 was reviewed. The	F 333	4. Director of Nursing and Unit Mangers will complete and audit weekly for 4 weeks and monthly for 2 months to ensure nurses continue to administer medication per physician's orders as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Date of Complaince:	07/29/17

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section for noting administration of the Novolog insulin was blank. The resident had blood sugars (BS) greater than 200 at 6 am on 6/1, 6/14, 6/15, and 6/21. The resident had BS greater than 200 at 2 pm on 6/1, and 6/22, 6/23, and 6/26. The resident had BS greater than 200 at 10 pm on 6/2, 6/7, 6/8, 6/13, 6/20, 6/21, and 6/22.

The comprehensive care plan was reviewed. The care plan contained intervention to obtain accuchecks as ordered and monitor for signs and symptoms of hyperglycemia (high blood sugar).

The unit manager (RN #2) was asked on 6/28/17 at approximately 8:00 a.m. about the missing insulin. The Novolog was listed under PRN medications and was not noticed by the nursing staff.

The administrator, director of nursing and corporate nurse consultant were informed of the findings during an end of the day meeting with the survey team on 6/28/17.

2. The facility staff failed to ensure Resident #3's Novolog insulin was administered as ordered by the physician.

The clinical record of Resident #3 was reviewed 6/27/17 and 6/28/17. Resident #3 was admitted to the facility 4/7/16 with diagnoses that included but not limited to cerebral palsy, diabetes mellitus, hypertension, iron deficiency anemia, hyperlipidemia, insomnia, constipation, contracture left elbow, pain, and scoliosis.

The clinical record of Resident #3 contained an annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/21/17. Resident #3 was coded with a cognitive summary

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score of 15 out of 15.

Resident #3's current comprehensive care plan dated 1/16/17 and revised 5/2/17 was reviewed 6/28/17 and included the focus of area of nutrition. Interventions: Administer medications as ordered.

Resident #3's most recent signed orders were dated 4/23/17 and included the following order for insulin: "Novolog Inject 5 units subcutaneously three times a day for DM (diabetes mellitus) Type 2."

The surveyor reviewed the June 2017 electronic medication administration record. Resident #3's eMAR contained an entry that read in part "Novolog Solution 100 unit/ML (milliliter) Insulin Aspart) Inject 5 unit subcutaneously three times a day for DM type 2 -Order Date-10/19/2016 1145." There were no initials in the box for 6/7/17 at 1200. The surveyor reviewed the June 2017 progress notes. There was no progress note written 6/7/17 by the nursing staff.

The surveyor interviewed the administrator in training about the insulin administration omission on 6/7/17 at 1200 noon on 6/28/17 at 4:30 p.m. After reviewing the progress notes and the medication administration record, the administrator in training stated she had no reason why Resident #3 did not receive insulin on 6/7/17 at 1200.

The surveyor informed the administrative staff of the above concern during the conference meeting on 6/29/17 at 11:20 a.m.

No further information was provided prior to the

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F 333	Continued From page 40 exit conference on 6/29/17.	F 333		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F 431 1. The maintenance Director permently secured the narcotic box to the refrigerator in the medication room on West and North wing on 06/28/17. 2. The Unit managers will complete an audit on 06/28/17 related to the narcotic boxes located in the refrigerators in the medication rooms on each wing of the facility to ensure the narcotic boxes are permently secured to the refrigerator as required 3. The licensed nureses re-educated by the Director of Nursing and Unit Managers by 07/21/17 to ensure narcotic boxes are permently secured to the refrigerators in the medication rooms on each wing. 4. Unit managers will conduct walk through round weekly for 4 weeks and monthly for 2 months to ensure narcotic boxes continue to be permentily secured to the refrigerators in the medication rooms on each wing as required. The Director of Nursing will submit a report to the Quality	

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F 431	Continued From page 41 (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, failed to ensure the narcotic boxes were permanently affixed on 2 of 2 units in the facility. The findings included: 1. On Unit 2, the facility staff failed to have the narcotic box permanently affixed in the refrigerator in which it is stored. On 6/29/17 at 9 am, the surveyor and Licensed Practical Nurse (LPN) #3 went into the medication room located behind the nursing station on Unit 2. In the medication room there were two small refrigerators one sitting on top of the other. The surveyor asked LPN #3 which refrigerator that the narcotics would be stored in. LPN #3 stated the top one that is locked. LPN #3 unlocked the refrigerator and inside the refrigerator on the second shelf, the surveyor	F 431	Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Date of Compliance:	07/29/17

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noted a clear plastic bag which contained Ativan 1mg/ml (milligram per milliliter) liquid injectable form of 3 bottles with a resident's name on them. The surveyor asked LPN #3 if this resident was still a resident on this unit and LPN #3 replied "yes". The clear plastic bag that contained the 3 bottles of Ativan was not in a permanently affixed narcotic box in the refrigerator.

At approximately 10:30 am on 6/29/17, the surveyor notified the administrative team of the above documented findings. The administrator stated "that will be fixed."

No further information was provided to the surveyor prior to the exit conference on 6/29/17.
2. The facility staff failed to ensure the narcotic box in the medication refrigerator in the medication room was securely affixed on the West unit.

The surveyor and licensed practical nurse #2 checked the medication room on the West unit on 6/28/17 at 2:05 p.m. The narcotic box in the refrigerator on the West Unit was not permanently affixed to a shelf. The narcotic box was locked but was easily removed from the refrigerator. The narcotic box contained a total of 9 doses of Ativan 2mg/1 ml (2 milligrams per 1 milliliter). L.P.N. #2 stated the box was easily removed and stated anyone could carry it out of the building if you had a key to the medication room.

The surveyor observed the maintenance director, the administrator, and the director of nursing in the medication room on 6/28/17 at 2:30 p.m. The maintenance director stated the refrigerator had been changed out recently. All three were

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F 431	Continued From page 43 observed in the medication room and stated they would work on a way to permanently affix the narcotic box in the refrigerator. The surveyor requested the facility policy on the storage of medications from the administrator in training on 6/28/17 at 3:25 p.m. The policy titled "Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles" was reviewed 6/29/17 at 9:10 a.m. The policy read in part "3. General Storage Procedures: 3.1 Facility should store Scheduled II Controlled Substances and other medications deemed by Facility to be at risk for abuse or diversion in a separate compartment within the locked medication carts and should have a different key or access device. 12. Controlled Substance Storage: 12.2 After receiving controlled substances and adding to inventory, Facility should ensure that Schedule II (2)-V (5) controlled substances are immediately placed into a secured storage area (i.e., a safe, self-locked cabinet, or locked room, in all cases in accordance with Applicable Law)." The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator in training of the above concern on 6/28/17 at 3:25 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference on 6/29/17.	F 431	F441 1. Resident #16 was re-assessed by the licensed nurse on 7/20/17 with no signs and syptoms of infection noted. Resident #17 was re-assessed by the licensed nurse on 07/20/17 with no signs and syptoms of infection noted. Licensed Nurse #1 was reeducated by Administrator on 07/07/17 related to the requirements of maintaining infection control procedures for washing hands while passing medication. 2. The Unit managers will complete med pass observaions beginning 07/21/17 to ensure established infection control procedures for washing hands while passing medications as required. 3. Licensed nurses will be re-educated by the Assistant Director of Nursing or Director of Nursing by 07/07/17 related to the requirements of maintaining established infection control procedures for washing hands while passing medications.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441		

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F 441	Continued From page 44 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 441	4. The Unit managers will conduct 2 medication pass observations per unit weekly for 4 weeks and monthly for 2 months to ensure established infection control procedures for washing hands while passing medications continues to be maintained as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Date of Compliance:	07/29/17

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F 441	Continued From page 45 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow established infection control guidelines during a medication pass and pour that affected 2 of 24 residents (Resident #16 and Resident #17). The findings included: The facility staff failed to wash their hands between Resident #16 and Resident #17 during a medication pass and pour observation on 6/28/17 with licensed practical nurse #1 and failed to wash hands after dropping a pill on the floor,	F 441		

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picking the pill off the floor with an ungloved hand, discarding the pill in the sharps container and then continuing with medication preparation.

A medication pass observation was conducted on 6/28/17 starting at 8:25 a.m. LPN #1 was observed setting up and administering medications to Resident #16 that included Lasix 20 mg (milligram) tablet, Klor Con 10 mEq (milliequivalent) tablet, Xanax 0.25 mg tablet, Amphetamine Salt 15 mg tablet, ASA 81 mg tablet, Centrum tablet, and two Antacids. After L.P.N. #1 had administered all of the resident's medications, L.P.N. #1 exited Resident #16's room and immediately began setting up Resident #17's medications and was observed administering them. LPN #1 did not wash hands after completion of the medication pass to Resident #16 and before preparing Resident #17's medications during the medication pass observation.

While L.P.N. #1 was preparing Resident #17's medications, one of Resident #17's medication landed on the floor (Keppra 750 mg). With an ungloved hand, L.P.N. #1 picked up the medication from the floor and discarded the medication in the sharps container. L.P.N. #1 then continued with the medication preparation and administered ten (10) medications to Resident #17 at 9:05 a.m. L.P.N. #1 failed to perform hand hygiene after picking up the medication from the floor and continuing the medication preparation.

The surveyor interviewed L.P.N. #1 on 6/28/17 at 9:35 a.m. L.P.N. #1 was asked when hands should be washed. She stated between residents. The surveyor informed L.P.N. #1 that

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the surveyor had not observed any type of hand hygiene. L.P.N. #1 stated "I thought I did." The surveyor also informed L.P.N. #1 when the pill on the floor was picked up by the nurse, this was done with a bare hand. L.P.N. #1 had no comment.

The surveyor requested the facility policy on handwashing during a medication pass from the administrator in training on 6/28/17 at 10:00 a.m.

The policy titled "Standard Precaution: Hand Hygiene" was reviewed 6/28/17 at 12:30 p.m. The policy read in part
"5. If hands are not visibly soiled, alcohol-based rubs are preferred for hand hygiene:
A. Before having direct contacts with residents.
B. After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings.
C. After contact with resident's intact skin.
D. If hands will be moving from a contaminated-body site to a clean-body site during patient care.
E. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident.
F. After removing gloves."

The surveyor informed the administrator, the director of nursing, the corporate registered nurse, and the administrator in training of the surveyor's observation during the medication pass on 6/28/17 at 3:25 p.m.

Resident #16 was admitted to the facility 8/17/15 with diagnoses that included multiple sclerosis, anxiety disorder, cauda equine syndrome, chronic pain, acute pulmonary edema, and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 48 gastroesophageal reflux disease. Resident #16's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/15/17 assessed the resident with a BIMS (brief interview for mental status) as 15 out of 15. Resident #17 was admitted to the facility 11/13/13 with diagnoses that included but not limited to traumatic hemorrhage of cerebrum, hypertension, urinary tract infection, aphasia, antiphospholipid syndrome, right hand contracture, right wrist contracture, and expressive language disorder. Resident #17's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/26/17 assessed the resident with short and long term memory problems and severely impaired cognitive skills for daily decision making. No further information was provided prior to the exit conference on 6/29/17.	F 441		
F 502 SS=E	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered laboratory tests for 8 of 24 residents (Resident #1, Resident #4, Resident #2, Resident #9, Resident #11, Resident #7, Resident #8, and Resident #13).	F 502	F 502 1. Resident #1's physician was notified by the licened nurse on 07/19/17 regarding the lab that was not obtained per physician's orders with new orders noted. Resident #4's physician was notified by the licened nurse on 07/19/17 regarding the lab that was not obtained per physician's orders with new orders noted. Resident #9's physician was notified by the licened nurse on 07/19/17 regarding the lab that was not obtained per physician's orders with new orders noted. Resident #2's physician was notified by the licened nurse on 07/19/17 regarding the lab that was not obtained per physician's orders with new orders noted. Resident #11's physician was notified by the licened nurse on 07/19/17 regarding the lab that was not obtained per physician's orders with new orders noted.	

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F 502	Continued From page 49 The findings included: 1. The facility staff failed to obtain a BMP (basic metabolic panel) for Resident #1. The clinical record of Resident #1 was reviewed 6/28/17 and 6/29/17. Resident #1 was admitted to the facility 4/14/16 and readmitted 1/10/17 with diagnoses that included but not limited to urine retention, urinary tract infection, hypertension, sepsis due to methicillin resistant staphylococcus aureus, altered mental status, hypokalemia, bilateral femoral neck fractures, hyperlipidemia, chronic pain, and chronic hepatitis. The quarterly MDS with an ARD of 5/8/17 assessed the resident with a cognitive summary score of 12 out of 15 in Section C Cognitive Summary. A telephone order dated 4/19/17 read in part "2. BMP in 2 weeks." The surveyor reviewed the laboratory section of the clinical record but was unable to locate the results. The surveyor informed the administrator in training and medical records (other #1) the results of the BMP were not located in the clinical record during an interview on 6/28/17 at 3:05 p.m. The administrator in training informed the surveyor on 6/29/17 at 10:00 a.m. that the BMP was not done as ordered. The surveyor informed the administrative staff of the above issue during the conference meeting on 6/29/17 at 11:20 a.m. No further information was provided prior to the	F 502	Resident #7's physician was notified by the licened nurse on 07/19/17 regarding the lab that was not obtained per physician's orders with new orders noted. Resident #8's physician was notified by the licened nurse on 07/19/17 regarding the lab that was not obtained per physician's orders with new orders noted. Resident #13's physician was notified by the licened nurse on 07/19/17 regarding the lab that was not obtained per physician's orders with new orders noted. 2. Unit managers will complete an audit by 07/28/17 related to labs orders for the past 60 days to unsure labs were drawn per physician's orders. 3. Licensed nurses will be re-educated by the Assistant Director of Nursing or Director of Nursing by 07/07/17 relatd to requirements of drawing labs per physician's orders. 4. Unit managers will complete audit weekly for 4 weeks and monthly for 2	

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F 502	Continued From page 50 exit conference on 6/29/17. 2. The facility staff failed to obtain stools for occult blood ordered on 9/7/16 and again on 9/26/16 for Resident #4. The clinical record of Resident #4 was reviewed 6/27/17 and 6/28/17. Resident #4 was admitted to the facility 4/28/11 and readmitted 10/17/16 with diagnoses that included but not limited to multiple sclerosis, paraplegia, bacterial infection, depressive disorder, hypotension, chronic pain, urinary tract infection, anemia, demyelinating disease, and type 2 Diabetes Mellitus. Resident #4's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/12/17 assessed the resident with a BIMS (brief interview for mental status) score as 15 out of 15. (a) A telephone order dated 9/7/16 read in part "2. Stool for OB (occult blood) x3." The surveyor reviewed the laboratory section of the clinical record for the results of the ordered laboratory tests but was unable to locate the results there. The surveyor requested the assistance of the unit manager registered nurse #2 on 6/28/17 at 10:30 a.m. The unit manager R.N. #2 stated the results of the stool for OB should be recorded on the medication administration record/treatment administration record. A review of the September 2016 Respiratory Administration Record had an entry that read "9/7/16 Stool OB X3." The boxes for 9/7/16 both 3-11 shift and 11-7 shift had a zero with a diagonal line through it and on 9/8/16, there were no recordings in the 7-3, 3-11, or 11-7 boxes. The surveyor reviewed the September 2016 ADL (activities of daily living) record. The	F 502	months to ensure labs continue to be drawn per physician's orders as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Date of compliane:	07/29/17

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record documented Resident #4 was incontinent of bowel on 9/7/16 and 9/8/16. The unit manager registered nurse #2 stated Resident #4 was always incontinent of bowel and the stools could have been obtained.

(b) A telephone order dated 9/26/16 read in part "2. Stool for OB x3." The surveyor reviewed the September 2016 medication administration record (MAR). The September 2016 MAR had an entry that read "Stool OB x3." There were no recorded results from 9/27/16 through 9/30/16. The September 2016 ADL record was also reviewed. Bowel function for 9/27/16 through 9/30/16 was recorded to be incontinent. The unit manager registered nurse #2 stated Resident #4 was incontinent of bowel and the stool sample could be obtained.

The surveyor informed the administrative staff of the above concern during the end of the day meeting on 6/28/17 at 3:25 p.m.

No further information was provided prior to the exit conference on 6/29/17.

3. The facility staff failed to obtain physician ordered laboratory testing for Resident #9.

Resident #9 was admitted to the facility on 3/27/16 with diagnoses of seizure disorder, depression, psychosis, PTSD, stroke, anxiety, and dementia with alcohol abuse.

The annual MDS with a reference date of 9/26/16 assessed the resident with a cognitive score of "6" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for dressing, toileting, bathing , and hygiene.

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The clinical record was reviewed. The current physician recertification orders contained orders with a start date of 10/29/16 to obtain a complete blood count (CBC), comprehensive metabolic panel (CMP), and a Magnesium level every 6 months in November and May.

The laboratory (lab) results were reviewed and the May for the CBC, CMP and Magnesium levels results were missing.

The unit manager (RN#1) was asked on 6/28/17 at 10:00 a.m. about the results. RN#1 reported back the lab tests were not done.

The administrator, director of nursing, assistant administrator, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 6/28/17 at 3:30 p.m.

4. The facility staff failed to obtain physician ordered laboratory testing for Resident #2.

Resident #2 was admitted to the facility on 8/25/16 with diagnoses of Type I diabetes, paraplegia, depression, insomnia, urinary retention, and schizoaffective disorder.

The quarterly MDS with a reference date of 5/18/17 assessed the resident with a cognitive score of "15"" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for dressing, toileting, bathing , and hygiene.

The clinical record was reviewed. The physician orders contained a written telephone order dated of 3/30/17 to obtain a complete blood count (CBC), basic metabolic panel (BMP), Lipid level (FLP) and a Hgb AIC every 6 months in March

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and September.

The laboratory (lab) results were reviewed and the March for the CBC, BMP, FLP, and HgbAIC results were missing.

The unit manager (RN#1) was asked on 6/28/17 at 10:00 a.m. about the results. RN#1 reported back the lab tests were not done.

The administrator, director of nursing, assistant administrator, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 6/28/17 at 3:30 p.m.
5. The facility staff failed to obtain laboratory tests as ordered by the physician for Resident #11.

Resident #11 was readmitted to the facility on 1/23/16 with the following diagnose of, but not limited to high blood pressure, diabetes, depression, end stage renal disease, and Bipolar Disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/9/17 the resident was coded as requiring extensive assistance from one staff member for dressing and bathing. Resident #11 had a BIMS (Brief Interview for Mental Interview) score of 15 out of a possible score of 15 on this MDS.

The surveyor conducted a clinical record review on Resident #11's clinical record on 6/27/17 and noted the resident had the following laboratory tests that were ordered by the physician: "CBC (Complete Blood Count) every 6 months, CMP (Comprehensive Metabolic Panel) every 3 months, FLP (Fasting Lipid Panel every 6 months and TSH (Thyroid Stimulating Hormone) every 6 months." These tests were scheduled to be

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obtained in December, 2016. The surveyor could not locate the laboratory results for the above documented laboratory tests.

On 6/28/17 at 3:30 pm, the administrative team was notified of the above documented findings by the surveyor.

On 6/29/17 at 8:30 am, LPN (Licensed Practical Nurse) #3 came to the surveyor and stated "the labs results that you are looking for, we didn't get them. Here is a nursing note that it was reported to the Nurse Practitioner (NP) but we didn't follow through with it." The surveyor read the nurses' note dated and timed for 12/6/16 at 10 am which stated, "Called placed to NP r/t (related to) pt (patient) refusing labs, new order received to draw labs following monitor and monitor."

No further information was provided to the surveyor prior to the exit conference on 6/29/17.
6. For Resident #7, the facility staff failed to obtain the physician ordered lab test BMP (basic metabolic panel) in May 2017.

The record review revealed that Resident #7 had been admitted to the facility 08/27/15. Diagnoses included, but were not limited to, mild intellectual disabilities, polyneuropathy, low back pain, dysphagia, anxiety, and chronic obstructive pulmonary disease.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/29/16 included a BIMS (brief interview for mental status) summary score of 14 out of a possible 15 points.

The Residents clinical record included a

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physicians order to obtain the lab test BMP every 3 months in February, May, August, and November. The clinical record did not include any results of the BMP for May 2017.

The administrative staff was notified of the missing lab test for May 2017 during a meeting with the survey team on 06/28/17 at approximately 3:25 p.m.

On 06/29/17 at approximately 7:50 a.m. LPN (licensed practical nurse) #1 verbalized to the surveyor that the May lab was not obtained.

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

7. For Resident #8, the facility staff failed to obtain the physician ordered lab tests CMP (comprehensive metabolic panel), CBC (complete blood count), HgbA1C (hemoglobin A1C), and vitamin D.

The record review revealed that Resident #8 had been admitted to the facility 06/22/15. Diagnoses included, but were not limited to, atrial fibrillation, syncope and collapse, hypothyroidism, diabetes, essential hypertension, and anxiety.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/30/17 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points.

Resident #8's clinical record included orders for the following lab tests. CBC every 6 months in May and November, CMP, HgbA1C, and vitamin

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F 502	Continued From page 56 D level every 3 months in February, Mary, August, and November. When reviewing the clinical record the surveyor was unable to locate the results for these labs for the month of May 2017. On 06/28/17 LPN (licensed practical nurse) #1 was asked about the missing lab results. On 06/28/17 at approximately 2:20 p.m. LPN #1 verbalized to the surveyor that the labs were not obtained. The administrative staff was notified of the missing lab tests during a meeting with the survey team on 06/28/17 at approximately 3:25 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 8. For Resident #13, the facility staff failed to obtain the physician ordered glucose lab tests. The record review revealed that Resident #13 had been admitted to the facility 11/15/16. Diagnoses included, but were not limited to, hypertension, diabetes, osteoarthritis, depressive disorder, edema, and cognitive communication deficit. Section C (cognitive patterns) of the Residents initial MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/25/16 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The clinical record included a physicians telephone order dated 02/03/17 that included the	F 502		

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F 502	Continued From page 57 order to check glucose once weekly (monitoring diabetes II). On 06/27/17 at approximately 4:15 p.m. the surveyor asked LPN (licensed practical nurse) #2 about the glucose order. On 06/28/17 at approximately 1:25 p.m. LPN #1 verbalized to the surveyor that this was for a lab tests and not for a finger stick to be done. Resident #13's clinical record only included the results of a glucose obtained on 02/07/17 with a BMP (basic metabolic panel) and on 02/28/17. The administrative staff was notified of the missing glucose lab tests during a meeting with the survey team on 06/28/17 at approximately 3:25 p.m. On 06/29/17 at approximately 7:45 a.m. LPN #1 verbalized to the surveyor that she was unable to locate any further lab tests in regards to the glucose. No further information regarding the missing glucose lab tests was provided to the survey team prior to the exit conference.	F 502	F 504 1. Resident # 4's physician was notified by the licensed nurse on 07/19/17 regarding labs that were obtained with out an order with no new orders noted. Resident # 12's physician was notified by the licensed nurse on 07/19/17 regarding labs that were obtained with out an order with no new orders noted. 2. Unit managers will complete an audit by 07/21/17 related to labs that were drawn in the last 30 days to ensure a physician's orders is in the medical record. 3. Licensed nurses will be re-educated by the Assistant Director of Nursing or Director of Nursing by 07/07/17 related to the requirement of obtaining a physician's orders prior to drawing labs. 4. The Unit managers will complete audit weekly for 4 weeks and monthly for 2 months to physician's orders continue to be obtained prior to drawing any labs as required.	
F 504 SS=D	483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN (a) Laboratory Services (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in	F 504		

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F 504	Continued From page 58 accordance with State law, including scope of practice laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain laboratory tests without a physician's order for 2 of 24 residents in the survey sample (Resident #4 and #12). The findings included: 1. The facility staff obtained a BMP without a physician order on Resident #4. The clinical record of Resident #4 was reviewed 6/27/17 and 6/28/17. Resident #4 was admitted to the facility 4/28/11 and readmitted 10/17/16 with diagnoses that included but not limited to multiple sclerosis, paraplegia, bacterial infection, depressive disorder, hypotension, chronic pain, urinary tract infection, anemia, demyelinating disease, and type 2 Diabetes Mellitus. Resident #4's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/12/17 assessed the resident with a BIMS (brief interview for mental status) score as 15 out of 15. A telephone order dated 10/2/16 read "1). TO (telephone order): Gentamicin IM (intramuscular) x 7 days pharmacy to figure dosage from labs. 2). Labs: BUN (blood urea nitrogen) and Creatinine." The surveyor reviewed the laboratory section of the clinical record and found the results of a BMP (basic metabolic panel) dated 10/2/16 that included the results of the BUN and Creatinine	F 504	The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Date of Complaince:	07/29/17

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F 504	Continued From page 59 ordered. However, the surveyor was unable to locate the physician order for the BMP. The surveyor reviewed the results of the laboratory test and the physician order for the BUN and Creatinine with the unit manager registered nurse #2 on 6/28/17 at 10:30 a.m. The unit manager R.N. #2 reviewed the physician's orders and stated she was unable to locate the order for the BMP completed on 10/2/16. The surveyor informed the administrative staff of the above concern during the end of the day meeting on 6/28/17 at 3:25 p.m. No further information was provided prior to the exit conference on 6/29/17. 2. For Resident #12, facility staff failed to ensure the ordered laboratory obtained a basic metabolic profile. Resident #7 was admitted to the facility on 7/29/16 with diagnoses including deep vein thrombosis, aftercare knee replacement, hypertension, peripheral vascular disease, anxiety, and depression. On the Minimum Data Set assessment with Assessment Reference Date 6/10/17, the resident scored 11/15 on the Brief Interview for Mental Status and was assessed as without signs of delirium, psychosis, or behaviors affecting others. During clinical record review on 6/28/17, the surveyor noted a physician order dated 5/5/17 for a CBC (complete blood count) and BMP (basic metabolic profile) in 1 week. Laboratory results dated 6/13/17 were for a CBC and a comprehensive metabolic profile (CMP). The	F 504		

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F 504	Continued From page 60 surveyor discussed the concern with the unit manager. The unit manager found the laboratory order sheet and confirmed that facility staff had ordered a basic metabolic profile. The administrator and director of nursing were notified of the concern during a summary meeting on 6/28/17.	F 504	F 508 1. Resident #11's physician was notified by the licensed nurse on 06/29/17 regarding the diagnostic test that was not completed per physician's order related to 1 view verse 2 view x-ray with new orders noted. 2. Unit managers will complete an audit by 07/21/17 related to physician's orders within the past 30 days to ensure diagnostic test were completed per physician's ordered. 3. Licensed Nurses will be re-educated by the Assistant Director of Nursing or Director of Nursing by 07/7/17 related to the requirement of completing diagnostic test per physician's orders. 4. Unit managers will complet audits weekly for 4 weeks and monthly for 2 months to ensure diagnostic test continue to be completed per phsyician's orders as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be	
F 508 SS=D	483.50(b)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS (b) Radiology and other diagnostic services. (1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a 2 view chest x-ray as ordered by the physician for 1 of 24 residents in the survey sample (Resident #11). The findings included: The facility staff failed to obtain a 2 view chest x-ray as ordered by the physician for Resident #11. Resident #11 was readmitted to the facility on 1/23/16 with the following diagnose of, but not limited to high blood pressure, diabetes, depression, end stage renal disease, and Bipolar Disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/9/17 the resident was coded as requiring extensive assistance from one staff member for	F 508		

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F 508	Continued From page 61 dressing and bathing. Resident #11 had a BIMS (Brief Interview for Mental Interview) score of 15 out of a possible score of 15 on this MDS. The surveyor conducted a clinical record review on Resident #11's clinical record on 6/27/17 and noted the resident had a physician order for a 2 view chest x-ray for the dates of 3/12/17 and 3/14/17. The surveyor found results in the clinical record of only a 1 view chest x-ray for these dates mentioned above. LPN (Licensed Practical Nurse) #3 was notified of the above documented findings. LPN #3 stated that he would look into this and get back with the answers. On 6/28/17 at 3:30 pm, the surveyor notified the above documented findings to the administrative team. On 6/29/17 at 8:30 am, LPN #3 came to the surveyor and stated "I have the answers you asked about on the two chest x-rays on this resident. I looked into it and called the mobile x-ray company we use and they stated that only a 1 view chest x-ray was all that could be obtained but didn't really tell me why when I asked." The surveyor asked LPN #3 if the physician was notified of only being able to obtain a 1 view chest x-ray instead of what he had originally ordered. LPN #3 stated "I couldn't find any notifications to the doctor or anything written in the nursing notes on these dates about the chest x-rays." No further information was provided to the surveyor prior to the exit conference on 6/29/17.	F 508	responsible for monitoring and follow up. Date of Complaince:	07/29/17
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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F 514	Continued From page 62 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessibfe; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure a complete and accurate clinical record for 2 of 24 Residents, Residents #21 and #11.	F 514	F 514 1. Resident #21's physician was notified by the licensed nurse on 07/19/17 related to the lack of documentation for administering medication with no new orders noted. Resident #21 was re-assessed by the licensed nurse on 07/20/17 with no change in condition noted. Resident #11's physician was notified by the licensed nurse on 07/19/17 related to the lack of documentation for administering insulin with no new orders noted. Resident #11 was re-assessed by the licensed nurse on 07/20/17 with no change in condition noted. 2. Unit managers will complete an audit of MARs by 07/20/17 to ensure documentation of medication is completed as required. 3. Licensed Nurses will be re-educated by the Assistant Director of Nursing or Director of Nursing by 07/07/17 related to the requirement of completing documentation of medication administration.	

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F 514	Continued From page 63 The findings included: 1. For Resident #21, the facility staff failed to document how much insulin had been administered. The record review revealed that Resident #21 had been re-admitted to the facility 05/12/17. Diagnoses included, but were not limited to, diabetes, bipolar disorder, chronic kidney disease, chronic pain, traumatic brain injury, and depression. Section C (cognitive patterns) of the Residents significant change MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/18/17 included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points. The Resident's clinical record included a physicians order for novolog sliding scale insulin before meals. The sliding scale order was as follows for a BS (blood sugar) of 200-250 =2 units of insulin, 251-300=4 units of insulin, 301-350-6 units of insulin, 351-400=8 units of insulin. The surveyor was unable to locate any information in the clinical record to indicate how much insulin the nursing staff had administered. The Residents blood sugars were documented and indicated insulin should have been administered everyday in June 2017 except the 25. On 06/29/17 at approximately 9:50 a.m. the DON (director of nursing) was asked about the missing insulin documentation and verbalized to the	F 514	4. Unit managers will complet audits weekly for 4 weeks and monthly for 2 months to ensure medication documentation continue to be completed and documented as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Date of Compliance:	07/29/17

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surveyor that the amount of insulin administered should be documented in the clinical record.

The administrative staff was notified of the missing documentation in regards to the Residents insulin during a meeting with the survey team on 06/29/17 at approximately 11:20 a.m.

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

2. The facility staff failed to have a complete and accurate clinical record for Resident #11 concerning administration of mediations.

Resident #11 was readmitted to the facility on 1/23/16 with the following diagnose of, but not limited to high blood pressure, diabetes, depression, end stage renal disease, and Bipolar Disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/9/17 the resident was coded as requiring extensive assistance from one staff member for dressing and bathing. Resident #11 had a BIMS (Brief Interview for Mental Interview) score of 15 out of a possible score of 15 on this MDS.

The surveyor conducted a clinical record review on Resident #11's clinical record on 6/27/17 and noted on the resident's MAR (Medication Administration Record) for the month of June, 2017 the following medications were not documented as administrated to the resident on 6/25/17 at 6 am: "Lantus Insulin Inject 10 units subcutaneously two times a day, Renvela Tablet 800 mg (milligram) Give 3200 mg by mouth three times a day and Tums Tablet Chewable Give 2 tablet by mouth three times a day." The boxes

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F 514	Continued From page 65 that were to be initialed by the nurse that administrated the medication to the resident were found by the surveyor to be left blank for the above mentioned medications with same dates and times as above documented. On 6/28/17 at 3:30 pm, the administrative team was notified of the above documented findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 6/29/17.	F 514	F 526 1. Resident # 18's plan of care was reviewed and updated by Hospice nurse on 06/29/17 with the hospice nurse to ensure resident care was corridinated with the hospice provider. 2. Unit Managers will complete an audit of hospice residents plan of care by 07/30/17 to ensure current plan of care is corridinated with the hospice provider including ensure hospice care plan is on the medical record. 3. The Unit Managers and Hospice provider will be re-educated by the Director of Nursing by 07/07/17 regarding the requirements of corridinating hospice resident's care including providing hospice care plan on the medical record. 4. The Unit managers will complete audits weekly for 4 weeks and monthly for 2 months to ensure hospice residents plan of care continues to be corridinated with the hospice provider including maintaining hospice care plan on the medical record. The Director of Nursing will submit a report to the	
F 526 SS=D	483.70(o)(1)-(4) Hospice (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply	F 526		

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F 526	Continued From page 66 to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition.	F 526	Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Date of Complaince: 07/29/17	

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F 526	Continued From page 67 (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.	F 526		

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(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

The designated interdisciplinary team member is responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related

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F 526	Continued From page 69 conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff	F 526		

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F 526	Continued From page 70 furnishing care to LTC residents. (4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to coordinate Hospice Services for 1 of 24 residents in the survey sample (Resident #18). The findings included: Resident #18 was admitted to the facility on 6/19/17. The entry MDS (Minimum Data Set) was the only MDS available to review at the time of the survey. According to the review of the clinical record review performed by the surveyor, the resident had the following diagnoses of, but not limited to late onset of Alzheimer's Disease, aspiration pneumonia, debility, general weakness, dysphagia, Sick Sinus Syndrome, complete heart block, cardiac pacemaker, atrial fibrillation and stroke. At the time of the initial nursing assessment, the resident "had her eyes open but was non-verbal." The resident was totally dependent on 2 staff members for personal hygiene and bathing. The surveyor performed a clinical record review of Resident #18's clinical record on 6/29/17. The surveyor noted during this review that there were	F 526		

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no Hospice services notes either in the electronic or paper clinical record. The surveyor asked Licensed Practical Nurse (LPN) #3 where the Hospice services notes were for the visits that they had made since the resident had been admitted to the facility on 6/19/17. LPN #3 stated that he would get back to the surveyor with this information. The current physician orders dated for 6/19/17 that was in the clinical record stated for Resident #18 to be admitted to the services of _____ (name of Hospice Agency).

At 10:45 am, the director of nursing came back to the surveyor and provided the copies of the Hospice orders, plan of care and visits notes of the skilled nursing visits and hospice aide visits. The surveyor asked the director of nursing where these were located and the director of nursing stated "I had to call the Hospice agency to obtain this information from them. They were faxed to me." The surveyor asked the director of nursing for a copy of the hospice contract.

According to the Hospice plan of care the resident would receive visits from the skilled nurse 2 times a week for 1 week then 1 time a week for 12 week. The Hospice aide would visit 1 time a week for 1 week then 2 times a week for 12 weeks. In the copies of the visit records that the director of nursing provided the surveyor, the skilled nurse had visited the resident in the facility on 6/20/17 and 6/27/17. The Hospice aide had made visits on 6/22/17 and 6/27/17. For each of these visits, the notes documented what care the resident received from each skilled nursing and Hospice aide visit that was made.

The surveyor was provided a copy of the hospice contract. In Section 1.14 of the contract it reads

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION & HEALTHCARE CENTER LLC	300 HATCHER STREET ROCKY MOUNT, VA 24151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 526	Continued From page 72 in part " ...Plan of care or POC means a coordinated plan of care for an individual Hospice Patient for the palliation or management of the Hospice Patient's terminal illness and related conditions ...is developed with the participation of Hospice, Facility, the Hospice Patient and the Hospice Patient's family as appropriate; (e) includes directives for managing pain and other uncomfortable symptoms; and (f) complies with applicable federal and state laws and regulations ..." In Section 2.8 of the hospice contract it reads in part " ...Hospice shall furnish to Facility (i) the most recent Hospice Plan of Care specific to each Hospice Patient, (ii) the hospice election form and any advance directives specific to each Hospice Patient, (iii) physician certification and recertification of the terminal illness specific to each Hospice Patient, ...(vi) Hospice medication information specific to each Hospice Patient, and (vii) Hospice physician and Attending Physician orders specific to each Hospice Patient ..." At approximately 10:30 am on 6/29/17, the administrative team was notified of the above documented findings by surveyor. No further information was provided to the surveyor prior to the exit conference on 6/29/17.	F 526		