STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	02/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER- PORTSMOUTH	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid MDS special focus survey was conducted 2/1/16 through 2/2/16. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. The census in this 120 certified bed facility was 104 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents #1 through #10).	F 000	This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid Requirements. Submission of this plan of correction does not constitutes an agreement that the deficiencies actually exist, nor is it an admission that they existed. This submission is a good faith expression of the facility's desire to fully comply with Medicare and Medicaid requirements.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to complete a Significant Change Minimum Data Set (MDS) assessment for 1 of 10 Residents in the sample survey, Resident #4. The Findings Included:	F 274	-F 274 The Significant Change MDS for resident #4 was opened immediately and completed. The care plan was updated per policy for the Significant Change. All residents have the potential to be affected. A review of residents with pressure ulcers, Foley catheters and readmissions within the last 30-days has been completed to assess for criteria for Significant Change. No new Significant Change needs were identified upon review. Director of Resident Assessment (DRA), Registered Nurse Assessment Coordinator (RNAC) and Administrative Clinical staff have been re-educated on the criteria	

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

Executive Director — 3/7/16

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

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F 274	Continued From page 1 For Resident #4 the facility staff failed to complete a Significant Change Minimum Data Set (MDS) assessment after a hospitalization and the emergence of a Stage III decubitus and the insertion of a Foley catheter. Resident #4 was a 68 year old female who was originally admitted on 11/25/15 and readmitted into the facility one 1/17/16. Admitting diagnoses included but were not limited to, bilateral pneumonia, anuria and oliguria, urinary tract infection, dehydration and deep vein thrombosis. The most current MDS located in the clinical record was a 5 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 1/09/16. The facility staff coded that Resident #4 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #4 required extensive (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's). In Section I. Bladder and Bowel the facility staff also coded that Resident #4 was 2 (frequently incontinent of bladder). The facility staff did not code that Resident #4 had an indwelling Foley catheter. In Section M. Skin Conditions the facility staff coded that Resident #4 had 6 (six) Stage I decubitus. On February 2, 2016 at 7:50 a.m. the surveyor observed Resident #4 lying in bed. The surveyor observed a Foley catheter tubing extending down the left side of the bed and a blue urinary drainage bag attached to the lower bed frame. On February 2, 2016 at 10:15 a.m. the surveyor reviewed Resident #4's clinical record. Review of the clinical record documentation that Resident #4 was discharged on 1/13/16 to a local hospital and readmitted into the facility on 1/17/16. Nurse's Notes dated 1/17/16 documented that Resident #4 had an indwelling Foley catheter and a pressure area on the sacrum that measured 1.5 cm by 1.9 cm. Additionally other pressure ulcers	F 274	for identifying Significant Change. Director of Resident Assessment (DRA) or designee will be present in Clinical Start Up to review resident readmission records to identify the need for Significant Change. DRA or Clinical Reimbursement Specialist will complete an audit of readmissions weekly to ensure that Significant Change MDS are completed as required. Identified issues or patterns will be brought to the QA committee for follow-up and recommendations x 3 months. At the completion of 3 months the QA committee will recommend if there is a need to continue.	03-11-16

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F 274	Continued From page 2 were also documented as being present. The location of the pressure ulcers were not documented, however, the notes documented that the areas measured 1.2 cm by 1.1 cm and 2.0 cm by 1.4 cm. Deep tissue injuries were also documented as being present on the right and left heels. Continued review of the clinical record produced a physician telephone order dated 1/22/16 that ordered a 16 French with 10 cc bulb Foley catheter for oliguria. Additional review of the clinical record produced the admission nursing assessment dated 1/17/16 that documented that Resident #4 had an indwelling Foley catheter, a stage II decubitus on the sacrum measuring 1.5 cm by 1 cm by 9 cm. The admission nursing assessment also documented two (2) decubitus on the anterior of the right anterior calf. The admission assessment documented the pressure ulcers as being 1.2 cm by 1.1 cm and 2.0 by 1.4 cm. Deep Tissue Injuries on the right and left heels were also documented. Further review of the clinical record produced a Wound Evaluation Flow Sheet dated 1/18/16 that documented that Resident #4 had a Stage III pressure ulcer on her sacrum that measured 1.8 cm by 2 cm by 0.1 cm. On February 2, 2016 at 11 a.m. the surveyor interviewed the MDS Nurse. The surveyor notified the MDS Nurse that when Resident #4 was readmitted into the facility on 1/17/16 and that a Significant Change MDS should have been done. The surveyor reviewed Resident #4's clinical record with the MDS Nurse. The surveyor pointed out the Nurse's Notes and Admission Nursing assessment documenting the pressure ulcers and the Foley catheter. The surveyor also reviewed the physician orders and the Wound	F 274		

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F 274	Continued From page 3 Evaluation Flow Sheet with the MDS Nurse. The surveyor notified the MDS Nurse that a Significant Change MDS should have been completed within 14 days of the time that the significant change occurred. The surveyor notified the MDS Nurse that Resident #17 was readmitted on 1/17/16. The surveyor notified the MDS Nurse that the facility staff had missed the 14 day targeted time frame for completing the Significant Change MDS. The surveyor asked the MDS Nurse if a Significant Change MDS should have been done and the MDS Nurse did not answer. The surveyor requested for the MDS Nurse to obtain the RAI (Resident Assessment Instrument) manual. The MDS Nurse obtained the manual and brought the manual back into the conference room. The MDS Nurse reviewed the MDS manual for a few minutes. The surveyor approached the MDS Nurse and reviewed the criteria for completing a Significant Change MDS assessment. The surveyor pointed out that 2 criteria had been met with the insertion/initiation of a Foley catheter and the emergence of a Stage III decubitus. On February 2, 2016 at 1:55 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and MDS Nurse. The surveyor notified the Administrative Team (AT) that Resident #4 was readmitted into the facility on 1/17/16 with the initiation of a Foley catheter and a Stage III decubitus on her sacrum. The surveyor notified the AT that the criteria had been met to complete a Significant Change MDS assessment. No additional information was provided as to why the facility staff failed to complete a Significant Change MDS assessment on Resident #4 on readmission into the facility on 1/17/16.	F 274		

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F 278	Continued From page 4	F 278		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for 4 of 10 Residents in the sample survey, Resident #2,	F 278	Resident #6, #1, #7 and #2 MDS were modified to accurately reflect the residents' conditions during the look back period. All residents have the potential to be affected by inaccurate MDS assessment and coding. An audit of current residents with noted conditions and/or devices in use in the last 90-days was completed. Identified issues were immediately corrected by assessment modifications and care plan updates. Director of Resident Assessment (DRA) and Registered Nurse Assessment Coordinator (RNAC) have been re-educated regarding coding and accuracy of MDS assessment. DRA or designee will complete three (3) weekly accuracy audits to assure the MDS reflects the resident and is coded accurately. Issues identified will be addressed immediately and MDS edits and/or modifications will be made as needed.	

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F 278	Continued From page 5 Resident #6, Resident #1 and Resident #7. The Findings Included: 1. For Resident #2 the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment. Resident #2 was receiving Abilify for a diagnosis of Schizophrenia and the facility staff failed to code/capture the diagnosis in Section I. Active Diagnoses I6100 Schizophrenia on a Correction of an Annual MDS assessment with an Assessment Reference Date (ARD) of 11/2/15. Resident #2 was a 73 year old female who was originally admitted on 10/25/09 and readmitted on 11/17/15. Admitting diagnoses included, but were not limited to: hypothyroidism, skin cancer, glaucoma, osteoarthritis, diabetes mellitus, hypertension, cerebrovascular accident, abdominal mass with radiation wound to the rectum and Schizophrenia. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Correction to an Annual MDS assessment with an ARD of 11/2/15. The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and had modified independence with decision making (1) regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #2 required extensive (3/2) to total nursing care (4/2) with ADL's. In Section I. Active Diagnoses I6100 Schizophrenia was not coded/captured. In Section N. Medications the facility staff coded that Resident #2 received 7 days of a psychotropic medication. On February 2, 2016 at 12:50 p.m. the surveyor reviewed Resident #2's clinical record. Review of	F 278	**Audit results will be brought to the QA committee for follow-up and recommendations x 3 months. At the completion of 3 months, the QA committee will recommend if there is a need to continue.**	03-11-16

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F 278	Continued From page 6 the clinical record produced signed Physician Orders Sheets (POS's) dated 1/30/16. Review of the POS's revealed the following orders ... "Abilify Tablet 5 mg (ARIPIprazole) Give 1 tablet by mouth one time a day related to SCHIZOPHRENIA (F20)." (sic) Abilify is a psychotropic medication. Continued review of the clinical record produced November 2015 Medication Administration Records (MAR's) that documented that the facility staff administered the Abilify as ordered by the physician. On February 2, 2016 at 9:40 a.m. the surveyor notified the Director of Nursing (DON) and MDS Nurse that Resident #2 was receiving Abilify, a psychotropic medication, for a diagnosis of Schizophrenia. The surveyor notified the DON and MDS Nurse that the Correction to an Annual MDS assessment with the ARD of 11/2/15 did not code/capture the diagnosis in Section I. Active Diagnoses I6100 Schizophrenia. The surveyor reviewed the clinical record with the MDS Nurse and pointed out the order for the Abilify and the diagnoses of Schizophrenia. On February 2, 2016 at 1:55 p.m. the survey team met with the Administrator (Adm), DON and MDS Nurse. The surveyor notified the Administrative Team (AT) that Resident #2 was receiving a psychotropic medication, Abilify, for diagnoses of Schizophrenia. The surveyor notified the AT that the diagnosis of Schizophrenia was not coded/captured on the Correction to an Annual MDS assessment with the ARD of 11/2/15. No additional information was provided prior to	F 278		

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F 278	Continued From page 7 exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #2. 2. For Resident #6 the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment. The facility staff failed to code/capture a Foley catheter on a 5 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 1/4/16 and on a 14 Day MDS assessment with an ARD of 1/11/16. Additionally the facility staff failed to accurately code Activities of Daily Living (ADL's) on the 14 day MDS assessment with the ARD of 1/11/16 and failed to code/capture Intravenous medication administration on the MDS. Resident #6 was a 67 year old female who was admitted on 12/28/15. Admitting diagnoses included, but were not limited to: anemia, diabetes mellitus, arthritis, osteomyelitis, urinary retention and morbid obesity. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 14 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 1/11/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #6 required extensive (3/2) to total nursing assistance (4/2) with Activities of Daily Living (ADL's) with the exception of the facility staff coding 8/8, indicating that the activity did not occur for the 7 day lookback period, for dressing, eating, personal hygiene and bathing. Additionally in Section H. Bladder and Bowel the facility staff did not code that Resident #6 had an indwelling Foley catheter. The facility staff coded that Resident #6 was continent of urine. Lastly in Section O. Special Treatments, Procedures, and Programs the facility staff did not code/capture that	F 278		

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F 278	Continued From page 8 Resident #6 received intravenous medications (IV). On February 2, 2016 at 7:45 a.m. the surveyor observed Resident #6 lying in bed and a Foley catheter tubing and urinary drainage bag on the right hand side of Resident #6's bed. The surveyor also observed an IV pole at the side of Resident #6's bed. On February 2, 2016 at 8:10 a.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record revealed physician orders. Physician orders included, but were not limited to: "14 fr (french) foley catheter. Change drainage bag as needed for leakage. Change foley catheter as needed for dislodgement. Foley cath (catheter) care every shift. Rocephin Solution Reconstituted (CefTRIAXone Sodium) ***DAW*** Use 1 gram intravenously every 24 hours for infection related to OTHER ACUTE OSTEOMYELITIS, UNSPECIFIED SITE (M86.10) until 2/10/16 23:59 Give 1 gram via picc (peripherally inserted central catheter) line q 24 hrs (every 24 hours) until 2/10/16." (sic) The orders for the Foley catheter and Rocephin intravenously initiated on 12/29/15. Additional review of clinical record revealed the January 2016 Medication Administration Records (MAR's). The January 2016 MAR's documented that the facility staff followed the physician orders and administered the Rocephin 1 Gram every 24 hours via the PICC line. Continued review of the clinical record revealed the daily ADL flow sheets. The ADL flow sheets documented that from 1/5/16 to 1/11/16 Resident #6 required extensive (3/2) to total nursing care (4/2) with dressing, was independent after tray set up (1/1) for eating and required extensive (3/2) to total nursing care (4/3) with personal hygiene and bathing.	F 278		

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F 278	Continued From page 9 Further review of the clinical record produced a 5 Day/Admission Medicare MDS assessment with an ARD of 1/4/16. The MDS coded that Resident #6 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #6 required extensive (3/3) to total nursing care (4/2) with ADL's. In Section H. Bladder and Bowel the facility staff did not code/capture that Resident #6 had an indwelling Foley catheter. The facility staff coded that Resident #6 was frequently incontinent of bladder. In Section O. Special Treatments, Procedures, and Programs the facility staff did code/capture that Resident #6 received intravenous medications (IV). On February 2, 2016 at 9:20 a.m. the surveyor met with the Director of Nursing (DON) and MDS Nurse. The surveyor notified the DON and MDS Nurse that Resident #6's MDS's with the ARD's of 1/11/16 and 1/4/16 were incorrect. The surveyor notified the DON and MDS Nurse that the MDS with the ARD of 1/11/16 did not accurately code/capture Resident #6's ADL status. The facility staff coded 8/8 for dressing, eating, personal hygiene and bathing, indicating that the ADL's were not done/did not occur. The surveyor also notified the DON and MDS Nurse that the MDS did not capture Resident #6s indwelling Foley catheter or Rocephin IV administration. Additionally the surveyor notified the DON and MDS Nurse that the MDS with the ARD of 1/4/16 did not code/capture Resident #6's indwelling Foley catheter. The surveyor reviewed the clinical record with the MDS Nurse. The surveyor reviewed the physician orders, January MAR's and the January 2016 ADL Flow sheets with the MDS Nurse. The surveyor then reviewed the MDS's with the ARD's of 1/11/16 and 1/4/16 with the MDS Nurse. The surveyor pointed out the inaccuracies on the MDS's.	F 278		

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F 278	Continued From page 10 On February 2, 2016 at 1:55 p.m. the survey team met with the Administrator (Adm), DON and MDS Nurse. The surveyor notified the Administrative Team (AT) that Resident #6 had multiple inaccuracies on the MDS's with the ARD's of 1/11/6 and 1/4/16. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #6. 3. For Resident #1, facility staff failed to ensure the minimum data set (MDS) assessment was coded accurately. Resident #1 was admitted to the facility on 8/28/15 with diagnoses including quadriplegia, sepsis, pressure ulcer, and bipolar disorder. On the admission MDS assessment dated 9/4/15, the resident scored 12/15 on the brief interview for mental status. The resident was coded 1 (occasionally incontinent) for urinary elimination and 2 (frequently incontinent) for bowel elimination status. During an interview on 2/2/15, the surveyor observed a urinary drainage bag hanging from the resident's bed. When asked, the resident stated that he had a urinary catheter and a colostomy. The resident's CNA confirmed that he had both. During clinical record review, the surveyor noted that the physician's history and physical and the nursing admission assessment noted the presence of urinary catheter and colostomy necessitated by the resident's quadriplegia. The surveyor noted that the quarterly MDS assessment dated 12/5/15 was not coded for the	F 278		

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F 278	Continued From page 11 urinary catheter. The surveyor interviewed the MDS coordinator about the resident's MDS assessments on 2/2/16. The MDS coordinator acknowledged the MDS was miscoded for urinary and bowel elimination. The resident's comprehensive care plan included a focus initiated 10/20/15 "alteration in elimination of bowel and bladder indwelling urinary catheter-urinary retention" addressed interventions related to urinary catheter care. It did not address colostomy care. The administrator and director of nursing (DON) were notified of the concern during a summary meeting on 2/2/16. 4. For Resident #7, facility staff failed to ensure the minimum data set (MDS) assessment was coded accurately. Resident #7 was admitted to the facility on 7/2/15 with diagnoses including hypertension, dementia, weight loss, and history of urinary tract infection (UTI). On the quarterly MDS assessment dated 1/8/16, the resident scored 6/15 on the brief interview for mental status and scored 2/8 for signs of delirium. The resident was assessed to be without behavior symptoms or symptoms of psychosis. The resident's diagnosis list did not include urinary tract infection. Clinical record review revealed a nurse's note dated 12/18/15 indicating complaint of burning on urination, a urinalysis positive for infection, and a new order for Bactrim antibiotic twice per day for 7 days for UTI. Daily nurse's notes document administration of antibiotic for UTI on 12/18	F 278		

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F 278	Continued From page 12 through 12/27/15. The resident's medication administration record(MAR) documented administration of Bactrim DS two times per day on 12/18/15 through 12/20/15 and Macrobid 100 mg twice per day 12/21 through 12/27/15. The administrator, director of nursing, and MDS coordinator were notified of the concern during a summary meeting on 2/2/16.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, it was determined that the	F 279	Care plans for Resident #2, #6, and #1 were immediately corrected to reflect the identified and triggered Care Area Assessments (CAA's) on the MDS and areas identified during assessment and interview for the MDS. An audit of current residents with noted conditions and/or devices in use in the last 90-days was completed by DRA. Identified issues were immediately corrected by the DRA through care plan updates. MDS staff were re-educated on requirements for review and revision of resident comprehensive plan of care. DRA or designee will complete random weekly comprehensive assessment audits to assure the triggered care area assessments are care planned per the care plan decision process. Issues	

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F 279	Continued From page 13 facility staff failed to develop a Comprehensive Care Plan (CCP) for 3 of 10 Residents in the sample survey, Resident #2, Resident #6 and Resident #1. The Findings Included: 1. For Resident #2 the facility staff failed to develop a Comprehensive Care Plan (CCP) for Communication as identified and triggered on a Correction to an Annual Minimum Data Set (MDS) assessment with the Assessment Reference Date (ARD) of 11/2/15. Resident #2 was a 73 year old female who was originally admitted on 10/25/09 and readmitted on 11/17/15. Admitting diagnoses included, but were not limited to: hypothyroidism, skin cancer, glaucoma, osteoarthritis, diabetes mellitus, hypertension, cerebrovascular accident, abdominal mass with radiation wound to the rectum and Schizophrenia. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Correction to an Annual MDS assessment with an ARD of 11/2/15. In Section C. Hearing, Speech, and Vision the facility staff coded that Resident #2 had minimal difficulty (1) in ability to hear, was usually able to make herself understood (1) and was usually able to understand others (1). The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and had modified independence with decision making (1) regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #2 required extensive (3/2) to total nursing care (4/2) with ADL's. In Section V. Care Area Assessment (CAA's) Resident #2 triggered for a Communication deficit. The facility staff	F 279	identified will be addressed immediately and care plan updates will be made as needed. Audit results will be brought to the QA committee for follow-up and recommendations x 3 months. At the completion of 3 months, the QA committee will recommend if there is a need to continue.	03-11-16

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F 279	Continued From page 14 documented that a Care Plan would be developed to address Resident #2's Communication deficit. On February 2, 2016 at 12:45 p.m. the surveyor attempted to interview Resident#2. The surveyor asked Resident #2 several questions. The surveyor asked Resident #2 how she was doing, if she was hungry, how had she slept and was breakfast good. Resident #2's response to each question was "I want too." On February 2, 2016 at 12:50 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced the CCP. Review of the CCP failed to produce a care plan that address Resident #2's Communication deficit. On February 2, 2016 at 1:15 p.m. the surveyor notified the MDS Nurse that Resident #2 had triggered for a Communication deficit on a Correction to an Annual MDS assessment with the ARD of 11/2/15. The surveyor notified the MDS Nurse that the facility staff had documented that a care plan would be developed to address Resident #2's Cognitive Deficit. The surveyor notified the MDS Nurse that review of the CCP failed to produce a care plan that addressed Resident #2's Communication Deficit. The surveyor reviewed the MDS and CCP with the MDS Nurse. The MDS Nurse was unable to locate a care plan that addressed Resident #2's Communication Deficit. On February 2, 2016 at 1:55 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and MDS Nurse. The surveyor notified the Administrative Team (AT) that Resident #2 had triggered for a Communication	F 279		

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F 279	Continued From page 15 Deficit on a Correction to an Annual MDS assessment with the ARD of 11/2/15. The surveyor notified the AT that the facility staff had documented that a care plan would be developed to address Resident #2's Communication Deficit. The surveyor notified the AT that review of the CCP failed to produce a care plan to address Resident #2's Communication Deficit. No additional information was provided prior to exiting the facility as to why the facility staff failed to develop a CCP for Resident #2 to include Communication. 2. For Resident #6 the facility staff failed to ensure develop a Comprehensive Care Plan (CCP) to include Falls as identified and triggered on a 5 Day Medicare and Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/4/16. Resident #6 was a 67 year old female who was admitted on 12/28/15. Admitting diagnoses included, but were not limited to: anemia, diabetes mellitus, arthritis, osteomyelitis, urinary retention and morbid obesity. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 14 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 1/11/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #6 required extensive (3/2) to total nursing assistance (4/2) with Activities of Daily Living (ADL's) with the exception of the facility staff coding 8/8, indicating that the activity did not occur for the 7 day lookback period, for dressing, eating, personal hygiene and bathing. On February 2, 2016 at 7:45 a.m. the surveyor observed Resident #6 lying in bed and a Foley	F 279		

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F 279	Continued From page 16 catheter tubing and urinary drainage bag on the right hand side of Resident #6's bed. On February 2, 2016 at 8:10 a.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record revealed physician orders. Physician orders included, but were not limited to: "14 fr (french) foley catheter. Change drainage bag as needed for leakage. Change foley catheter as needed for dislodgement. Foley cath (catheter) care every shift."(sic) The order for the Foley catheter on 12/29/15. Continued review of the clinical record produced a 5 Day/Admission Medicare MDS assessment with an ARD of 1/4/16. The MDS coded that Resident #6 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #6 required extensive (3/3) to total nursing care (4/2) with ADL's. In Section J. Health Conditions the facility staff coded that Resident #6 had had a fall in the last month prior to admission/entry or reentry. In Section V. Care Area Assessment (CAA's) Resident #6 triggered for falls and the facility staff coded that a care plan would be developed to address Resident #6's potential for falls. Further review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP failed to produce a care plan that addressed Resident #6's potential for falls. Additionally the care plan failed to address Resident #6's alteration in urination, i.e. Foley catheter. On February 2, 2016 at 9:20 a.m. the surveyor met with the Director of Nursing (DON) and MDS Nurse. The surveyor notified the DON and MDS Nurse that Resident #6 had triggered for falls on the 5 Day Medicare and Admission MDS assessment with the ARD of 1/4/16. The surveyor notified the DON and MDS Nurse that the facility staff had documented that a care plan	F 279		

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F 279	Continued From page 17 would be develop to address Resident #6's potential for falls. The surveyor notified the DON and MDS Nurse that review of the CCP failed to produce a care plan that addressed Resident #6's potential for falls. The surveyor reviewed the MDS and CCP with the MDS Nurse. The MDS Nurse was unable to locate a care plan that addressed Resident #6's potential for falls. Lastly the surveyor notified the DON and MDS Nurse that Resident #6 had an indwelling Foley catheter and that a care plan had not been developed to address Resident #6 ' s alteration in elimination, i.e. Foley catheter. On February 2, 2016 at 1:55 p.m. the survey team met with the Administrator (Adm), DON and MDS Nurse. The surveyor notified the Administrative Team (AT) that Resident #6 had triggered for falls on the 5 Day Medicare and Admission MDS. The surveyor notified the AT that the facility staff had documented that a care plan would be developed to address Resident #6's potential for falls. The surveyor notified the AT that review of the CCP failed to produce a care plan that addressed Resident #6's potential for falls. The surveyor also notified the AT that Resident #6 had an indwelling Foley catheter and that a care plan had not been developed to address Resident #6's alteration in elimination, i.e. indwellingFoley catheter. No additional information was provided prior to exiting the facility as to why the facility staff failed to develop a CCP to include fall potential and the indwelling Foley catheter for Resident #6. 3. For Resident #1, facility staff failed to develope a care plan for necessary care for a resident. Resident #1 was admitted to the facility on 8/28/15 with diagnoses including quadriplegia,	F 279		

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F 279	Continued From page 18	F 279		

sepsis, pressure ulcer, and bipolar disorder. On the admission MDS assessment dated 9/4/15, the resident scored 12/15 on the brief interview for mental status. The resident was coded 1 (occasionally incontinent) for urinary elimination and 2 (frequently incontinent) for bowel elimination status.

During an interview on 2/2/15, the surveyor observed a urinary drainage bag hanging from the resident's bed. When asked, the resident stated that he had a urinary catheter and a colostomy. The resident's CNA confirmed that he had both.

During clinical record review, the surveyor noted that the physician's history and physical and the nursing admission assessment noted the presence of urinary catheter and colostomy necessitated by the resident's quadriplegia. The surveyor noted that the quarterly MDS assessment dated 12/5/15 was not coded for the urinary catheter or colostomy.

The surveyor interviewed the MDS coordinator about the resident's MDS assessments on 2/2/16. The MDS coordinator acknowledged the MDS was miscoded for urinary and bowel elimination.

The resident's comprehensive care plan included a focus initiated 10/20/15 "alteration in elimination of bowel and bladder indwelling urinary catheter-urinary retention" addressed interventions related to urinary catheter care. It did not address colostomy care.

The administrator and director of nursing (DON) were notified of the concern during a summary meeting on 2/2/16.

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to anchor an indwelling Foley catheter to prevent excessive tension on the urinary meatus for 1 of 10 Residents in the sample survey, Resident #2. The Findings Included: For Resident #2 the facility staff failed to anchor an indwelling Foley catheter to prevent excessive tension on the urinary meatus. Resident #2 was a 73 year old female who was originally admitted on 10/25/09 and readmitted on 11/17/15. Admitting diagnoses included, but were not limited to: hypothyroidism, skin cancer, glaucoma, osteoarthritis, diabetes mellitus, hypertension, cerebrovascular accident, abdominal mass with radiation wound to the rectum and Schizophrenia. The most current Minimum Data Set (MDS)	F 315	-F 315 Resident #2's indwelling Foley catheter was immediately anchored to prevent excessive tension on the urinary meatus, per policy for indwelling catheters. Family and physician were notified per protocol. Education was provided to the Responsible Party (RP) related to contraindications of not anchoring the Foley catheter to prevent excessive tension on the meatus per policy. RP expressed understanding and agreement. A 100% audit of residents with Foley catheters was completed to assure proper physician orders for anchoring were in place and that care plans reflected proper anchoring orders. No issues identified per audit. Re-education was provided to nurses and CNA's on the purpose of each resident with a Foley catheter to have a leg strap to relieve tension on the meatus per policy and physician orders. New admissions and residents that require the need for a Foley catheter will be validated for proper orders for Foley catheter anchor and care plan accordingly by	

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F 315	Continued From page 20 assessment located in the clinical record was a Correction to an Annual MDS assessment with an Assessment Reference Date (ARD) of 11/2/15. The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and had modified independence with decision making (1) regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #2 required extensive (3/2) to total nursing care (4/2) with ADL's. In Section H. Bladder and Bowel the facility staff coded that Resident #2 had an indwelling catheter. On February 2, 2016 at 8 a.m. the surveyor observed Resident #2 lying in bed and receiving care from 2 (two) Certified Nursing Assistants (C.N.A.'s #1 and #2). The surveyor observed a urinary drainage bag attached to the right hand side of Resident #2's bed frame. The surveyor observed a Foley catheter tubing extending out from the right hand side of the bedlinens. The surveyor asked the 2 C.N.A.'s if they could lift Resident #2's bedlinens so that the surveyor could observe if Resident #2's Foley catheter was anchored. The C.N.A's lifted Resident #2's bedlinens to expose Resident #2's lower extremities. The surveyor observed the Foley catheter tubing extending out of Resident #2's right brief leg. The surveyor observed that the Foley catheter tubing then ran under Resident #2 and that Resident #2 was lying on the Foley catheter tubing. Resident #2's Foley catheter was not anchored. The surveyor asked the C.N.A.'s if the Foley catheter was supposed to be anchored and the C.N.A.'s stated, "Yes." On February 2, 2016 at 8:15 a.m. the surveyor reviewed the facility policy and procedure titled, "Catheter Care, Indwelling Catheter" that had	F 315	clinical management staff. Daily Clinical Start Up review will assess residents with new catheter orders and assure correct physician orders and care plan for those orders. Issues identified will be addressed immediately and care plan updates will be made as needed. Random audits weekly will be conducted by DNS and/or designee to assure that Foley Catheters are anchored according to physician orders and care plan. Audit results will be brought to the QA committee for follow-up and recommendations x 3 months. At the completion of 3 months, the QA committee will recommend if there is a need to continue.	03-11-16

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been left in the conference room on February 1, 2016. The policy and procedure read in part ... "Procedure Purpose: To prevent infection. To reduce irritation. ...Procedure Details: ... 7. Ensure catheter is anchored using strap or other anchoring device."

On February 2, 2016 at 12:50 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced signed Physician Orders Sheets (POS's) dated 1/30/16. Review of the POS's revealed the following orders for Foley catheter care: "Catheter in place 16 French 10ml balloon r/t (related to) radiation wounds and comfort every shift related to SQUAMOUS CELL CARCINOMA OF SKIN, UNSPECIFIED (C44.92). Change catheter 16 fr (French) and drainage bag as needed every shift related to SQUAMOUS CELL CARCINOMA OF SKIN, UNSPECIFIED (C44.92)." (sic) Continued review of the clinical record produced documentation that Resident #2's Foley catheter was initiated on 11/10/15.

On February 2, 2016 at 9:40 a.m. the surveyor notified the Director of Nursing (DON) and MDS Nurse that Resident #2's Foley catheter had not been anchored to prevent tension on the urinary meatus and to prevent injury from the Foley catheter being pulled out.

On February 2, 2016 at 1:55 p.m. the survey team met with the Administrator (Adm), DON and MDS Nurse. The surveyor notified the Administrative Team (AT) that Resident #2 had a Foley catheter and that the catheter was not anchored.

No additional information was provided prior to exiting the facility as to why the facility staff failed

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F 315	Continued From page 22 to anchor Resident #2's Foley catheter to prevent excessive tension on the urinary meatus.	F 315		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 356	-F356 The posted nurse staffing data was immediately updated to include the total number and the actual hours worked by Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants directly responsible for resident care per shift. An immediate modification was made by Staffing Coordinator to display the total number and actual hours worked per category required for licensed and unlicensed staff directly responsible for resident care per shift going forward in each daily posting. Re-education was provided to all Management staff and Charge Nurses on the posting requirement to reflect the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. Random audits will be completed weekly by ED/DNS/designee to assure proper posting per shift, to include actual hours worked by those staff members. Any findings will be	

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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 356	Continued From page 23 Based on observation and staff interview, facility staff failed to post the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. During initial tour on 12/1/16, the surveyor observed nurse staffing numbers posted on a bulletin board across from the dining room. The posting included the date, the resident census for each shift, and the number of registered nurses, licensed practical nurses, and certified nursing assistants scheduled to work each shift. The posting did not include actual hours worked by those staff members. The surveyor discussed the issue with the director of nursing on 2/1/16. The director of nursing acknowledged.	F 356	corrected immediately and re-education given as needed. Audit results will be brought to the QA committee for follow-up and recommendations x 3 months. At the completion of 3 months, the QA committee will recommend if there is a need to continue.	03-11-16
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	-F514 The Attending Physician for Resident #2 was called to obtain a change in medication orders to have all medications administered via peg tube. The family was notified of medications to be administered via peg tube. Physician orders and care plan were updated accordingly. All residents with peg tube orders were validated for proper administration route of medications. No findings were identified per audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	02/02/2016

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F 514	Continued From page 24 by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for 1 of 10 Residents in the sample survey, Resident #2. The Findings Included: For Resident #2 the facility staff failed to ensure complete and accurate Physician Order Sheets (POS's) and Medication Administration Records (MAR's). Resident #2 was a 73 year old female who was originally admitted on 10/25/09 and readmitted on 11/17/15. Admitting diagnoses included, but were not limited to: hypothyroidism, skin cancer, glaucoma, osteoarthritis, diabetes mellitus, hypertension, cerebrovascular accident, abdominal mass with radiation wound to the rectum and Schizophrenia. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Correction to an Annual MDS assessment with an ARD of 11/2/15. The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and had modified independence with decision making (1) regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #2 required extensive (3/2) to total nursing care (4/2) with ADL's. On February 2, 2016 at 12:50 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced signed POS's. The POS's were signed by the physician on 1/20/16. Review of the signed POS's reveal that some of Resident #2's medications were ordered to be	F 514	Re-education of licensed nurses was provided on following physician orders and on medication administration for peg tube residents. Random weekly med pass observations and physician order review throughout facility on peg tube residents will be conducted by DNS/ADNS/designee to assure proper medication administration per physician orders. Findings will be corrected immediately and re-education provided as needed. Audit results will be brought to the QA committee for follow-up and recommendations x 3 months. At the completion of 3 months, the QA committee will recommend if there is a need to continue.	03-11-16

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F 514	Continued From page 25	F 514		

administrated by mouth while other medications were ordered to be administered by PEG tube (percutaneous endoscopic gastrostomy). Signed physician orders included, but not limited to: "Enteral Feed order five times a day FREE water flush 160 mL five times a day. Enteral feeding Order five times a day related to TYPE 1 DIABETES MELLITUS WITHOUT COMPLICATIONS (E10.9) Glucerna 1.2 cal. Abilify Tablet 5MG (ARIPIprazole Give 1 tablet by mouth one time a day related to SCHIZIOPHRENIA (F20). Actonel Tablet 150MG (Risedronate Sodium) Give 1 tablet by mouth one time a day every 30 day (s) related to UNSPECIFIED OSTEOARTHRITIS, UNSPECIFIED SITE (M19.90). Aspirin Tablet 81 MG Give 1 tablet by mouth one time a day related to UNSPECIFIED ATRIAL FIBRILLATION (148.91). CloNIDine HCL Tablet 0.2mg Give 1 tablet by mouth three times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10). Flomax Capsule 0.4MG (TAMSULOSIN HCL) Give 1 capsule by mouth one time a day related to FREQUENCY OF MICTURITION (R35.0). HydrALAZINE HCL Tablet 25 MG Give one tablet two times a day related to ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS (I25.10).Lexapro Tablet 10MG (Escitalopram Oxealate) Give 1 tablet by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, INSPECIFIED (F32.9). Lopressor Tablet 50MG (Metoprolol Tartrate) Give 1 table by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10). Plavix Tablet 75MG (Clopidogrel Bisulfate) Give 1 tabley by mouth one time a day related to ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT

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F 514	Continued From page 26 ANGINA PECTORIS (I25.10). Prolosec OTC Tablet Delayed release 20 MG (Omeprazole Magnesium) Give 1 table by mouth one time a day related to GASTRO-ESPHAGEAL REFLUX DISEASE WITHOUT ESPHAGITIS (K92.9). Synthroid Tablet (Levothyroxine Sodium) Give 1.5mg by mouth one time a day for underactive thyroid. Zocor tablet 40MG (Simvastatin) Give 1 tablet by mouth in the evening related to ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS (I25.10)." (sic) All other medications were ordered to be administered by PEG tube. Continued review of the clinical record produced the January and February 2016 MAR's. Review of the MAR's documented that some of the medications were being administered by mouth while others were being administered by PEG tube. On February 2, 2016 at 1:40 p.m. the surveyor interviewed the medication nurse, who was a Licensed Practical Nurse (LPN (#1), how Resident #2 received her medications. LPN (#1) stated that Resident #2 received all of her medications by PEG tube. The surveyor asked LPN (#1) if she was aware that some of Resident #2's medications were ordered to be administered by mouth while other medications were ordered to be administered via PEG tube. LPN (#1) stated, "I've never paid attention to that." The surveyor reviewed the signed POS's and MAR's with LPN (#1). LPN (#1) stated she would call the physician and get the orders corrected. On February 2, 2016 at 1:55 p.m. the survey	F 514		

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F 514	Continued From page 27 team met with the Administrator (Adm), Director of Nursing (DON) and MDS Nurse. The surveyor notified the Administrative Team (AT) that Resident #2's POS's and MAR's were incorrect. The surveyor notified the AT that some of Resident #2's medications were ordered to be administered by mouth while others were ordered to be administered by PEG tube. The surveyor notified the AT that all of Resident #2's medications were being administered by PEG tube. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #2.	F 514		