STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495353	A. BUILDING _____ B. WING _____	C 01/29/2016

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HERITAGE HALL BLACKSTONE	900 S MAIN ST BLACKSTONE, VA 23824

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/27/16 through 1/29/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 180 certified bed facility was 144 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #1 through #21) and five closed record reviews (Residents #22 through #26).	F 000		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and employee record review, it was determined that the facility staff failed to complete background screenings for 4 of 5 employee records reviewed in accordance with the facility abuse policy. For OSM #12 (Other Staff Member, activities director), OSM #13 (dietary), LPN #11 (Licensed Practical Nurse), and CNA #11 (Certified Nursing Assistant) the facility staff failed to complete the 30 day criminal background check with the	F 226	**F226** **Corrective Action(s):** The Activity Director #12, the Dietary employee #13, the LPN # 11 and the CNA #11 have all had the required sworn disclosure statements completed and criminal background checks completed from the appropriate state agency. The third party company used for obtaining background checks is no longer performing this task. **Identification of Deficient Practices & Corrective Action(s):** All other employees may have been potentially affected. The Human Resources department will audit 100% of all active employee records to identify employees at risk. Any/all negative findings will be corrected at the time of discovery. A Facility Incident and Accident Report will be completed for any/all negative findings.	

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FEB 19 2016
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nina Bottsdale | TITLE: Administrator | (X6) DATE: 2-17-16

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 226	Continued From page 1 required state agency; and failed to obtain the required sworn statement, both which were conditions set forth in the facility policy which was not implemented. The findings include: A review of the facility "Criminal Background Check Policy" policy documented, "Policy Statement: In order to assure a safe, secure and productive environment for all employees, residents, volunteers and visitors at our facilities, a policy and program of background checks will be required on any applicant before they can be hired. This policy will be effective July 1, 2014....1. Criminal record checks will be conducted in accordance with applicable law. Applicants or employees will be notified if a criminal record check will be conducted and will be asked to complete a Disclosure and Authorization form authorizing (name of corporation) to conduct a criminal record search. If requested, the applicant or employee will be provided with a copy of this criminal background check policy." A review of the employee records of 5 new hires from the last 4 months prior to survey was conducted. Of these records, 4 did not contain the 30 day background check from the required state agency; and did not contain a sworn statement, per applicable laws and facility policy. Instead, the facility was using a third party company to conduct the background check. In addition, the form that was being utilized as a sworn statement did not include any statements regarding the applicant was free from convictions of any barrier crimes and did not have any	F 226	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. Administrative Staff, Department Managers and the HR department will be inserviced and issued a copy of the policy & procedure by the Administrator. Administrative Staff and Department Heads extending employment without meeting the requirements of the established facility policy & procedure will receive disciplinary action. Perspective employees will not be allowed to work until all required documentation has been obtained. **Monitoring:** The Human Resources Manager is responsible for maintaining compliance. The Human Resources Director and/or designee will conduct monthly audits of all new hire employee files for each month to maintain compliance. The administrator will review all audits and report aggregate findings to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date:** 3-14-16 RECEIVED FEB 18 2016 VDH/OLC	

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F 226	Continued From page 2	F 226		

pending charges. Instead, this form documented statements that the applicant authorizes the procurement of a consumer report by a credit reporting agency as part of the pre-screening background investigation; an investigative consumer report which may contain information about employment and educational background, criminal history, credit, workers comp claims, mode of living, character, personal reputation; authorizes all corporations, companies, former employers, supervisors, credit agencies, educational institutions, law enforcement/criminal justice agencies, city, state, county, and federal courts, state motor vehicle bureaus and persons to release any information they may have about (applicant) and further authorize that these consumer investigative reports may be procured at any time, any number of times, before, during and after employment; and stated that the applicant hold harmless all parties involved from any and all liability for damages arising from requesting, procuring or furnishing the requested information.

On 1/28/16 at 1:45 p.m., an interview was conducted with OSM #5 (HR [Human Resources] and payroll.) She stated that around mid-October (2015) the facility began using a third party agency for conducting these required screenings and that she had questioned the screenings and sworn statements that were being utilized. She stated that as of "three weeks ago" (approximately the beginning of January 2016) the facility began to again use the required agency for background checks and the sworn statement that was required by law, in addition to what the third party agency was doing, but that for the 4 records reviewed, there was no further information as those screenings were conducted

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F 226	Continued From page 3 solely by the third party agency during the period of mid-October 2015 to the beginning of January 2016. On 1/28/16 at the end of day meeting at approximately 5:30 p.m., the ASM #1(Administrative/Corporate Staff, the Administrator), ASM #2 (the Director of Nursing), RN #1 (Registered Nurse, the Assistant Director of Nursing), and ASM #3 (the regional nurse consultant) were made aware of the findings. No further information was provided by the end of the survey.	F 226		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review facility staff failed to provide activities that meet the needs and interests of one of 26 residents in the survey sample; Resident #7. The Facility staff failed to provide activities to meet the needs and interests of Resident #7. The findings include: Resident #7 was admitted to the facility on 8/4/15 and readmitted on 12/11/15 with diagnoses that	F 248	**F248** **Corrective Action(s):** Resident #7 has been reassessed for activities. Resident #7's plan of care was updated to reflect her activity needs and interests with appropriate interventions to meet her needs. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents with severe cognitive impairment may have been potentially affected. The facility conducted a 100% review of all severely cognitive residents to identify residents at risk. Residents identified at risk will have their care plans reviewed to determine if the resident's care plan has activities listed to meet the resident's individual psychosocial needs and interests. Any changes or additional findings will be added to their resident specific care plan.	

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F 248	Continued From page 4 included but not limited to high blood pressure, type two diabetes, stroke, dysphagia (difficulty swallowing), severe peripheral vascular disease and muscle weakness. Resident #7's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 12/18/15. The resident was coded as never understanding others and never being understood by others for communication. Resident #7 was coded as being severely impaired in the ability to make daily decisions. The resident was coded as being totally dependent on staff with transfers, dressing, eating, personal hygiene and bathing. Several observations were made of Resident #7 on the following dates: 1/27/16 at 1:55 p.m., Resident #7 was lying in bed on back, eyes open and non-verbal. TV was not on, no radio or music playing. Resident #7 was staring up at the ceiling. 1/27/16 at 6:00 p.m., Resident #7 was sleeping in bed on right side. No TV or music playing. 1/28/16 at 7:30 a.m., Resident #7 was not in the room. Activities were not in session at this time. 1/28/16 at 10:00 a.m., Resident #7 was lying in bed, feet elevated, and eyes open and non-verbal. No music, TV, or any other activities were observed being made available to the resident. 1/28/16 2:00 p.m., Resident #7 was lying in bed with eyes open. No music, TV or any other activities were observed being made available to the resident. 1/28/16 at 4:45 p.m., incontinence care was observed. After care, Resident #7 was not offered an activity to participate in by CNA (certified nursing assistant) #12. 1/29/16 at 9:45 a.m., Resident #7 was lying in	F 248	**Systemic Change(s):** The current facility policy and procedure has been reviewed and no changes are warranted at this time. The current Activities Director and Activity Assistant will review the Long Term Care regulation manual for providing activities and to develop activity programs to meet resident specific needs and interests. **Monitoring:** The Activities Director is responsible for maintaining compliance. Weekly audits of activity coding on Comprehensive MDS assessments and activity care plans will be conducted by the Activity Director and/or RCC coinciding with the MDS calendar to monitor for compliance. All negative findings will be reported to the Risk Management Committee for review. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion date:** 3-14-16	

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F 248	Continued From page 5 bed with eyes open. No music, TV or any other activities were observed being made available to Resident #7. Review of Resident #7's most recent MDS with an ARD (assessment reference date) of 12/18/15 documented under Section F "Preferences for Customary Routine and Activities the following:" "F0800. Staff Assessment of Daily and Activity Preferences" Resident Prefers: Check all that apply: A check was documented under the following activities: "I. Family or significant other involvement in care discussions M. Listening to music T. Participating in religious activities or practices." Review of Resident #7's care plan dated 12/18/15 documented in part, the following under Activities: "Provide resident with volunteer visits. Activities will provide a MP3 player with music of family choice for the resident. Activities will provide books in resident room for friends and family to read to her." Review of the January 2016 activity calendar log revealed that Resident #7 had not participated in any group activities. Review of Resident #7's individual activity log revealed her last activity was with the activity assistant on 1/13/16. The activity log documented the following: "Intervention Nail, gospel music; Duration/Time: 20 minutes." On 1/29/16 at approximately 9:15 a.m., an interview was conducted with OSM (other staff member) #14, the activities assistant. When asked how often she visits Resident #7 for one to	F 248		

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one activities she stated that she tries to see Resident #7 at least once a week. When asked the last time she visited Resident #7 she stated, "A week and 1/2 ago." When asked what activities Resident #7 likes to do she stated, "Well I just offer her activities and she will shake her head yes or no if she wants to do the activity or not. Like last week I painted her nails." When asked if there was a reference she could use to determine Resident #7's likes or dislikes she stated, "Not that I am aware of." When asked if she refers to Resident #7's MDS or care plan for activity preferences she stated, "No." When pointed to the care plan and asked why Resident #7 did not have a MP3 player in her room OSM #14 stated, "I'm not sure. We keep MP3 players in the office but she doesn't have one." When asked how Resident #7 listens to music, OSM #14 stated that she comes in with a hand held kiosk and plays music for the resident. She stated that each activity usually lasts 20-30 minutes. When asked why she had not come in to see Resident #7 the week of survey she stated, "I actually lost my handheld Kiosk to do activities with her. I just found it today in my desk so I will visit her as soon as possible." When asked if Resident #7 attends group activities she stated, "No." When asked why, OSM #14 stated, "I think she is bedridden." When asked if there was a way to find out how Resident #7 transfers or if she can get out of bed, she stated, "I am not sure."

On 1/29/16 at 9:45 a.m., an interview was conducted with LPN (licensed practical nurse) #12, the nurse on duty for Resident #7. When asked if Resident #7 is bedridden she stated, "No, she gets out of the bed and into a reclining chair." When asked her transfer status she stated

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F 248	Continued From page 7 Resident #7 needs a hoyer lift. When asked if Resident #7 would benefit from group activities, LPN #12 stated, "Yes, I suppose she could go to an activity because she is becoming more alert now." The activities director could not be reached for an interview. On 1/29/16 at 10:00 a.m., administration was made aware of the above findings. No further information was provided during survey. Facility policy titled, "Activities" documents in part, the following: "Goal and Purpose: To provide a diverse program of activities that motivate individuals to utilize their physical, psychological, and social attributes, and to establish a meaningful life style while residing at (name of facility)... The best way to learn about which activities residents will enjoy is to get to know each resident personally. However, this can be difficult and there are a few other sources Activities employees can use to learn about what activities residents like and which ones they'll be able to participate in...The sources include... Activity analyses and assessments, MDS, Care plan, Progress notes, Records of resident participation, resident council meetings."	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	**F250** **Corrective Action(s):** Resident #9 has been assessed by social services and his attending physician for the need for psychological services. A referral for a psychological evaluation has been ordered. Resident #9's	

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F 250	Continued From page 8 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 provide medically related social services to meet the psychosocial needs of two of 26 residents in the survey sample, Residents #9 and #14. 1. The facility staff failed to follow-up on a physician's order for a psychological consult for Resident #9. 2. The facility staff failed to follow-up on further psychological services recommended by a provider for Resident #14. The findings include: 1. Resident #9 was admitted to the facility on 10/7/11 with diagnoses including, but not limited to: history of a stroke with paralysis on one side of his body; dementia, psychosis, and major depression. On the most recent MDS (minimum data set), a significant change assessment with assessment reference date (ARD) 10/28/15, he was coded as being moderately impaired for making daily decisions, having scored eight out of ten on the BIMS (brief interview for mental status). He was coded as having demonstrated exit-seeking behaviors during the look back period. A review of the clinical record for Resident #9 revealed the following physician's order, written 4/1/15: [Name of mental health services	F 250	comprehensive care plan has been revised to reflect the current approaches and interventions to address his behaviors. A Facility Incident & Accident Form has been completed for this incident. Resident #14 has been assessed by social services and his attending physician for the need for psychological services. A referral for a psychological evaluation has been ordered. Resident #14's comprehensive care plan has been revised to reflect the current approaches and interventions to address his behaviors. A Facility Incident & Accident Form has been completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who have orders for psychiatric and/or psychological referrals and evaluations may have been potential affected. The social service director will conducted a 100% review of all residents with medically related psychosocial needs requiring psychiatric and/or psychological intervention to identify residents at risk. Residents identified at risk will be seen by Social Services for psychosocial interventions. All care plans will be updated to reflect the current approaches and interventions.	

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F 250	Continued From page 9 provider] to eval (evaluate) and treat." Further review of the clinical record revealed no evidence that this order had been followed. On 1/28/16 at 9:20 a.m., ASM (administrative staff member) #1, the administrator, was asked to provide the surveyor with evidence of all psychological/mental health consults for Resident #9. On 1/28/16 at 1:20 p.m., OSM (other staff member) #3, the social worker, approached the surveyor and gave her a copy of a document with the above-referenced mental health services provider's letterhead. The document was dated 1/28/16. Review of this document revealed, in part, the following: "To Whom It May Concern: On April 24, 2015, we received a referral from [name of facility] to see [Resident #9] for Mental Health Services. Our Intake Department determined this patient was not eligible for our service due to not having Medicare Part B." The document was signed by an executive vice president of the mental health services company. OSM #3 stated: "They did not see him because they do not accept his insurance." When asked what the facility staff had done to arrange for another mental health services provider for Resident #9, OSM #3 stated: "I don't believe they ever put him on the list to be seen by the psychologist who comes here to see residents." OSM #3 stated: "I only started here July first (2015). They did not communicate with me that he needed anything." When asked whose job it is to make sure residents receive needed mental health services, she stated: "I guess it's my job to follow up and make sure it's done. I'll have them put him on the list."	F 250	**Systemic Change(s):** The Social Services director will receive additional in-service training for identifying and providing psychosocial support from the administrator. Social services will monitor all residents showing changes in behaviors, signs of depression, and increased anxiety to provide timely and appropriate interventions to meet their psychosocial needs. Social services will provide a detailed monthly report to the Administrator documenting evidence of psychosocial support provided. **Monitoring:** The Administrator and the Social Services Director are responsible for maintaining compliance. The Social Service Director will audit resident records monthly coinciding with the MDS calendar to monitor for compliance. The results of these audits will be provided to the Quality Assurance Committee for review, analysis, and make recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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F 250	Continued From page 10 A review of the comprehensive care plan for Resident #9 dated 10/7/11 and updated 10/28/15, revealed, in part, the following: "Continued care by facility staff per PCP (primary care physician) and physician orders...Will observe for moods/behaviors and psychosocial needs." On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. Policies and procedures regarding mental health services were requested. On 1/29/16 at 8:10 a.m., ASM #1 stated: "We don't have that kind of policy. We do have a job description for the social worker." A review of the document entitled "Social Services Director" revealed, in part, the following: "The Social Services Director plans, organizes, and directs programs that facilitate the social, psychological, and physiological well-being of each resident...Assume responsibility for referral of residents to social, health, and community agencies. Document referrals in resident records." No further information was provided prior to exit. 2. Resident #14 was admitted to the facility on 7/15/14 and most recently readmitted on 12/21/15 with diagnoses including, but not limited to: *Asperger syndrome, **schizophrenia and diabetes. On the most recent MDS, a significant change assessment with an ARD of 12/28/15, Resident #14 was coded as having scored 15 out	F 250		

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F 250	Continued From page 11	F 250		

of 15 on the BIMS. He was coded as having disorganized thinking, as having verbal behaviors directed toward others during the look-back period.

A review of the physician's orders for Resident #14 revealed the following order written 12/21/15: "[Name of mental health services provider] to eval (evaluate) and treat for behavioral health services."

Further review of the clinical record revealed a consult note from the mental health service provider dated 7/23/15. A review of this note revealed, in part, the following: "TREATMENT PLAN: Problem: Depression. Plan: Pt (patient) refuses meds (medications) but is willing to get talk therapy...Offer therapy services/refer to Psychology...Discharge from my clinic as refusing meds but is willing to get psychotherapy and is very gregarious (talkative)."

On 1/28/16 at 1:20 p.m., OSM (other staff member) #3, the social worker, was interviewed regarding the recommendation for further psychotherapy for Resident #14. She stated: "I just missed it." When asked what the process is for providing residents with psychotherapy as recommended by providers, she stated: "I receive the notes from [name of evaluating agency]. Then I give a copy to the unit and I keep a copy to follow up on. I just missed this. I guess I need to put him on the list for [name of psychologist who provides services at the facility]." She explained that the provider who recommended the further therapy for Resident #14 only does evaluations remotely - that is, the evaluator is not on facility property and the evaluation is done long-distance via computer

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F 250	Continued From page 12 technology. She stated the evaluator and the resident are able to see each other and converse by way of computer screens. A review of the comprehensive care plan for Resident #14 dated 12/28/15 revealed, in part, the following: "Observe for changes in mental status. Provide consistent caregiver." On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. No further information was provided *"Asperger syndrome (AS) is a developmental disorder. It is an autism spectrum disorder (ASD), one of a distinct group of neurological conditions characterized by a greater or lesser degree of impairment in language and communication skills, as well as repetitive or restrictive patterns of thought and behavior." This information is taken from the website http://www.ninds.nih.gov/disorders/asperger/asperger.htm. **"Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website http://www.nimh.nih.gov/health/publications/schizophrenia-booklet-12-2015/index.shtml	F 250		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings	F 252	**F252** **Corrective Action(s):** Resident #11's torn fall mat has been replaced. A facility Incident & Accident form was completed for this incident.	

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F 252	Continued From page 13 to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a clean, comfortable homelike environment for one of 26 residents in the survey sample, Resident #11. The facility staff failed to maintain Resident #11's fall mat in good repair. The findings include: Resident #11 was admitted to the facility on 6/15/15 with diagnoses that included but were not limited to: muscle weakness, cardiac arrhythmia (a problem with the rate or rhythm of your heartbeat*) and low blood pressure. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/24/15, coded the resident's cognitive skills for daily decision making as being severely impaired. Resident #11 was coded as being totally dependent of one staff with locomotion on the unit. Resident #11's comprehensive care plan with a problem onset date of 6/18/15 documented, "Fall mat at bedside, check placement q (every) shift when resident in bed..." On 1/27/16 at 2:40 p.m. and 1/28/16 at 8:00 a.m., Resident #11 was observed in a wheel chair in the dining room. Observation of Resident #11's room revealed the resident's fall mat was folded	F 252	**Identification of Deficient Practice(s) and Corrective Action(s):** All other resident's utilizing fall mats while bed may have potentially been affected. A complete documented environmental walkthrough of the facility will be conducted by the administrator, maintenance director, and environmental services director to identify residents at risk. All resident fall mats identified that are torn will be removed from service and replaced immediately at the time of discovery. **Systemic Change(s):** The facility's policy & procedure for providing a safe, sanitary, and comfortable environment has been reviewed. No changes are warranted at this time. The Maintenance Director and/or Environmental Director will provide inservices to all staff on facility policy and procedure on the notification system to use when repairs and cleaning are needed throughout the facility. **Monitoring:** The Environmental Director and the Maintenance Director is responsible for maintaining compliance. Documented facility rounds will be completed weekly to monitor compliance. The administrator will review weekly to ensure negative findings are being corrected. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice **Completion Date:** 3-14-16	

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F 252	Continued From page 14 and sitting against the foot of the resident's bed. A torn area approximately four inches long by one half inch wide was observed on the edge of the mat. Foam was exposed sticking out of the plastic covering. On 1/28/16 at 1:32 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked how staff ensures residents' fall mats are maintained in good repair without torn areas. CNA #1 stated, "If we see it torn we put in a work request to have it changed or go to the supervisor and let the charge nurse know." When asked if she had noticed any torn areas on Resident #11's fall mat, CNA #1 stated she had not. CNA #1 stated she didn't use the resident's fall mat and it was utilized by night shift. When asked if Resident #11 ever took naps during the day shift, CNA #1 stated the resident only naps during the day once in a while. At this time, CNA #1 was taken to Resident #11's room and shown the fall mat. CNA #1 stated she would report the torn fall mat and removed the mat from the room. On 1/28/16 at 4:25 p.m., an interview was conducted with CNA #2. CNA #2 was asked who was responsible for ensuring fall mats were kept clean and free from torn areas. CNA #2 stated she didn't think anyone did that and she had never seen anyone do that. When asked how to keep a torn fall mat clean and free of bacteria, CNA #2 stated, "I don't think you can. I would get a new one." On 1/28/16 at 5:52 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.	F 252		

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F 252	Continued From page 15 The facility policy titled, "Quality of Life- Homelike Environment" documented in part, "Residents are provided with a safe, clean, comfortable and homelike environment...2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order..." No further information was presented prior to exit. *This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/arrhythmia.html	F 252		
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence;	F 272	F272 **Corrective Action(s):** Residents #4 & #12 identified in the survey sample have had their Care Area Assessment Summary revised to reflect the date of the of documentation describing each resident's clinical status and other factors that may impact care planning decisions. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially affected. A 100% review of all Care Area Assessment Summary's will be completed by the RCC and/or designee to identify residents affected. All residents affected will have their Care Area Assessment Summary's corrected at time of discover.	

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F 272	Continued From page 16 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide the location and date on the CAA (Care Area Assessment) summary worksheet of the MDS (minimum data set) assessments for two of 26 residents in the survey sample, Residents # 4 and 12. 1. The facility staff failed to document the location and date of the information describing the resident's clinical status and factors impacting care planning decisions on Section V-Care Area Assessment (CAA) Summary of Resident # 4's MDS (Minimum Data Set) a significant change assessment, with an ARD (Assessment Reference Date) of 6/8/15. 2. The facility staff failed to document the location	F 272	**Systemic Change(s):** The facility policy and procedure was reviewed and no changes are warranted at this time. The regional nurse consultant will inservice the Resident Care Coordinator's and the interdisciplinary Care Plan Team on accurately completely the Care Area Assessment Summary. This will include accurate documentation indicating the date and location of documentation describing each resident's clinical status and other factors that impact care planning. **Monitoring:** The RCC is responsible for maintaining compliance. The RCC will complete MDS audit tool weekly coinciding with the MDS calendar to monitor for compliance. Any/all negative findings will be reported to the RCC and the DON at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date:** 3-14-16	

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F 272	Continued From page 17 and date of the information describing the resident's clinical status and factors impacting care planning decisions on Section V-Care Area Assessment (CAA) Summary of Resident # 12's MDS (Minimum Data Set) a significant change assessment, with an ARD (Assessment Reference Date) of 6/12/15. The findings include: 1. Resident # 4 was admitted to the facility on 7/29/14 readmitted on 6/1/15 and again readmitted on 1/26/16 with diagnoses that included, but were not limited to: diabetes, hypertension, hyperlipidemia, dementia, depression, glaucoma, gastroesophageal reflux disease, coronary artery disease, and benign prostatic hypertrophy. Resident # 4's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/7/15. Resident # 4 was coded as an 8 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was cognitively impaired. Review of Resident # 4's most recent comprehensive assessment, the significant change assessment with an ARD of 6/8/15, revealed in Section V - CAA, that dates of information documented under the heading, "Location and Date of CAA Information", was missing. Section A - CAA results documented that Resident # 4 triggered the following CAA areas: Cognitive Loss/Dementia Visual Function	F 272		

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F 272	Continued From page 18 Communication Urinary Incontinence and Indwelling Catheter Falls Nutritional Status Dehydration/Fluid Maintenance Dental Care Pressure Ulcer Under the columns, "Location and Date of CAA documentation" for the following triggered areas the location of the information used to complete the CAA was documented but the date of the information was not documented as instructed: Cognitive Loss/Dementia Visual Function Dental Care During an interview on 1/28/16 at 11:50 a.m. with LPN (Licensed Practical Nurse) # 1 an MDS Coordinator this MDS was reviewed. LPN # 1 was asked about the missing dates in the CAA summary and LPN # 1, after reviewing the MDS, responded, "All that information was in the Resident's clinical record, I just didn't put the dates in." LPN # 1 was asked if she had a policy to guide her with completion of Section V. RN (Registered Nurse) #2, an MDS Coordinator, responded, "We use the RAI (Resident Assessment Instrument) manual." Section V of the MDS documents at the top of the page the following instructions: "1. Check column A if the Care Area is triggered. 2. for each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Addressed in	F 272		

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F 272	Continued From page 19 the Care Plan column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan. 3. Indicate in the Location and Date of CAA information column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks and any referrals for this resident for this care area." During an interview on 1/28/16 at 4:00 p.m. with ASM (Administrative Staff Member) # 1, the Administrator, and ASM # 3, the Regional Nurse Consultant, these findings were shared. No further information was provided prior to the end of the survey. 2. Resident # 12 was admitted to the facility on 3/7/11 and readmitted on 12/23/13 with diagnoses that included, but were not limited to: congestive heart failure, seizures, hypertension, depression, macular degeneration, gout, Alzheimer's disease, and arthritis. Resident # 12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/11/15. Resident #12 was coded as being severely impaired for daily decision making. Review of Resident # 12's most recent comprehensive assessment, the significant change assessment with an ARD of 6/12/15, revealed in Section V - CAA, that dates of information documented under the heading, "Location and Date of CAA Information", was	F 272		

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F 272	Continued From page 20 missing. Section A - CAA results documented that Resident # 4 triggered the following CAA areas: Cognitive Loss/Dementia Visual Function Communication ADL Functional/Rehabilitation Potential Urinary Incontinence and Indwelling Catheter Behavioral Symptoms Activities Falls Nutritional Status Pressure Ulcer Psychotropic Drug Use Physical Restraints Under the columns, "Location and Date of CAA documentation" for the following triggered areas the location of the information used to complete the CAA was documented but the date of the information was not documented as instructed: Visual Function Activities Nutritional Status During an interview on 1/28/16 at 11:50 a.m. with LPN (Licensed Practical Nurse) # 1, an MDS Coordinator, this MDS was reviewed. LPN # 1 was asked about the missing dates in the CAA summary and LPN # 1, after reviewing the MDS, responded, "All that information was in the Resident's clinical record, I just didn't put the dates in." LPN # 1 was asked if she had a policy to guide her with completion of Section V. RN (Registered Nurse) #2, an MDS Coordinator, responded, "We use the RAI (resident assessment instrument) manual."	F 272		

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F 272	Continued From page 21 During an interview on 1/28/16 at 4:00 p.m. with ASM (Administrative Staff Member) # 1, the Administrator, and ASM # 3, the Regional Nurse Consultant, these findings were shared. No further information was provided prior to the end of the survey.	F 272		
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.	F 278	**F278** **Corrective Action(s):** Resident #11's Admission MDS Assessment with and ARD of 6/25/15 was reviewed by the RCC and a modification was completed to accurately code resident #11'1 height. Resident #7's Significant Change MDS assessment with and ARD of 12/18/15 was reviewed by the RCC and a modification was completed to accurately code section C (cognitive patterns). Resident #7's Quarterly MDS assessment with and ARD of 11/20/15 was reviewed by the RCC and a modification was completed to accurately code section D (Mood). Resident #5's Annual MDS assessment with and ARD of 9/10/15 and quarterly MDS assessment were reviewed by the RCC and modifications were completed to accurately code Cognition and conduct interviews for Mood. Resident #12's Quarterly MDS assessment with and ARD of 12/11/15 was reviewed by the RCC and a modification was completed to accurately code resident #11'1 Race/ethnicity.	

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F 278	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate MDS (minimum data set) for four of 26 residents in the survey sample, Residents #11, #7, #5 and #12. 1. The facility staff failed to code Resident #11's height on the admission MDS assessment with an ARD (assessment reference date) of 6/25/15. 2a. The facility staff failed to properly code Section C (cognitive patterns) of Resident #7's significant change (Minimum Data Set) assessment with an ARD (assessment reference date) of 12/18/15. 2b. The facility staff failed to attempt a resident interview for section D "Mood" on Resident #7's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/20/15. 3. The facility staff failed to conduct the interviews for cognition and mood on Resident #5's annual MDS (minimum data set) assessment with an assessment reference date (ARD) 9/10/15; and failed to conduct the interview for mood on the quarterly MDS assessment with ARD 12/10/15. 4. For Resident # 12 the facility staff failed to accurately code Section A 1000. Race/Ethnicity on Resident # 12's Quarterly MDS (Minimum Data Set) Assessment with an ARD (Assessment Reference Date) of 12/11/15.	F 278	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have been potentially been affected. A 100% audit of all current resident MDS assessments will be completed by the RCC and/or designee to ensure that MDS sections A – Race/Ethnicity, section C – Cognitive Patterns, section D - Mood interview and section K – Height are assessed and coded correctly. All negative findings will be reported to the RCC for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS. **Systemic Change(s):** The Resident Interdisciplinary Care Team have been inserviced by the Regional Nurse consultant on the proper assessment and interviewing and coding of all areas of the MDS to include sections A, C, D, K of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data.	

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F 278	Continued From page 23 The findings include: 1. The facility staff failed to code Resident #11's height on the admission MDS assessment with an ARD (assessment reference date) of 6/25/15. Resident #11 was admitted to the facility on 6/15/15 with diagnoses that included but were not limited to: muscle weakness, cardiac arrhythmia (a problem with the rate or rhythm of your heartbeat*) and low blood pressure. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/24/15, coded the resident's cognitive skills for daily decision making as being severely impaired. Review of Resident #11's admission MDS assessment with an ARD of 6/25/15 revealed the resident's height was coded as "00" inches in Section K. On 1/28/16 at 11:00 a.m., an interview was conducted with RN (registered nurse) #2 (the MDS coordinator). RN #2 confirmed she didn't code Resident #11's height on the admission MDS assessment. RN #2 stated staff hadn't obtained a height on the resident and she should have went and obtained the height herself. RN #2 stated she references the RAI (Resident Assessment Instrument) manual when completing MDS assessments. On 1/28/16 at 5:52 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The CMS (Centers for Medicare and Medicaid	F 278	**Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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	495353	A. BUILDING _____ B. WING _____	C 01/29/2016

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F 278	Continued From page 24 Services) RAI manual documented the following: "K0200: Height and Weight Planning for Care ·Height and weight measurements assist staff with assessing the resident's nutrition and hydration status by providing a mechanism for monitoring stability of weight over a period of time. The measurement of weight is one guide for determining nutritional status. Steps for Assessment for K0200A, Height 1. Base height on the most recent height since the most recent admission/entry or reentry. Measure and record height in inches... Coding Instructions for K0200A, Height ·Record height to the nearest whole inch..." No further information was presented prior to exit. *This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/arrhythmia.html 2a. The facility staff failed to properly code Section C (cognitive patterns) of Resident #7's significant change (Minimum Data Set) assessment with an ARD (assessment reference date) of 12/18/15. Resident #7 was admitted to the facility on 8/4/15 and readmitted on 12/11/15 with diagnoses that included but not limited to: high blood pressure, type two (II) diabetes, stroke, dysphagia (difficulty swallowing), severe peripheral vascular disease and muscle weakness. Resident #7's most recent MDS (minimum data set) was a significant	F 278		

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F 278	Continued From page 25 change assessment with an ARD of 12/18/15. The resident was coded as never understanding others and never being understood by others for communication. Resident #7 was coded as being severely impaired in the ability to make daily decisions. The resident was coded as being totally dependent on staff with transfers, dressing, eating, personal hygiene and bathing. Review of Resident #7's most recent MDS, a significant change assessment with an ARD of 12/18/15 revealed that Section B "Hearing, Speech and Vision" in part, documented the following: "B0700. Makes Self Understood; Ability to express ideas and wants, consider both verbal and non-verbal expression. 0. Understood 1. Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time. 2. Sometimes understood -ability is limited to making concrete requests. 3. Rarely/Never understood." A "3" was coded under B0700 indicating the resident was rarely understood. Section B0800. "Ability to understand others" documented the following: "Understanding verbal content, however able (with hearing aid or device if used) 0. Understands-clear comprehension 1. Usually understands-misses some part/intent of message but comprehends most conversation. 2. Sometimes understands-responds adequately to simple, direct communication only. 3. Rarely/never understands." A "3" was coded indicating that the resident rarely or never understands others. Section C (Cognitive Patterns) of the MDS documented the following:	F 278		

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F 278	Continued From page 26 "C0100. Should Brief Interview for Mental Status (C0200-C0500) should be conducted? Attempt to conduct interview with all residents" 0. No (Resident is rarely/never understood) --> Skip to and complete C0700-C1000, Staff Assessment for Mental Status. 1. Yes --> Continue to C0200, Repetition of three words" A "0" was documented indicating the individual interview would not be attempted due to the resident's cognitive status. C0500, "Summary Score" of cognitive status documented the following: "Add scores for questions C0200-C0400 and fill in total score (00-15). Enter 99 if the resident was unable to complete the interview." A "00" (Zero) was documented under C0500 indicating that Resident #7 had a BIMS score of zero and that an individual interview had been attempted. Section C0600, "Staff assessment for Mental Status" was also completed for Resident #7. Resident #7 was coded a "3" under C1000 (Cognitive skills for daily decision making) indicating the resident was severely cognitively impaired to make daily decisions. On 1/28/16 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the MDS coordinator. When asked about section C of Resident #7's MDS she stated that section C0500 should have been coded as a 99 not a zero. She stated that the resident was never understood and that an individual interview would not be attempted. She stated, "I should have paid more attention. I should have documented a 99 not a zero." LPN #1 stated that she uses the RAI (Resident Assessment Instrument) manual when completing the MDS assessment. On 1/28/16 at 5:26 p.m., administration was	F 278		

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F 278	Continued From page 27 made aware of the above findings. No further information was presented during survey. The RAI (Resident Assessment Instrument) manual documents in part the following under section "C0500: Summary Score:" "Coding Instructions: Record whether the cognitive interview should be attempted with the resident. -Code 0, no: If the interview should not be attempted because the resident is rarely/never understood or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status. -Code 1, yes: If the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words... Code 99, unable to complete interview: if (a) the resident chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response, or (c) if any of the BIMS items is coded with a dash." 2b. The facility staff failed to attempt a resident interview for section D "Mood" on Resident #7's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/20/15. Review of Resident #7's comprehensive MDS, a quarterly assessment with an ARD of 11/20/15 revealed that Section B "Hearing, Speech and Vision" in part, documented the following: "B0700. Makes Self Understood, Ability to express ideas and wants, consider both verbal and non-verbal expression. 0. Understood	F 278		

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F 278	Continued From page 28 1. Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time. 2. Sometimes understood -ability is limited to making concrete requests. 3. Rarely/Never understood." A "1" was coded under B0700 indicating the resident was usually understood. Section B0800. "Ability to understand others" documented the following: "Understanding verbal content, however able (with hearing aid or device if used) 0. Understands-clear comprehension 1. Usually understands-misses some part/intent of message but comprehends most conversation. 2. Sometimes understands-responds adequately to simple, direct communication only. 3. Rarely/never understands." A "2" was coded indicating that the resident sometimes understands others. Section D (Mood), of the MDS documented the following: "D0100. Should Resident Mood Interview be conducted? -Attempt to conduct interview with all residents. 0. No (resident is rarely/never understood) --> Skip to and complete D0500-D0600, Staff Assessment of Resident Mood 1. Yes --> Continue to D0200, Resident Mood Interview" A "0" zero was coded under section D0100 indicating that the resident is rarely or never understood. Section D0500 (Staff Assessment of Resident Mood) was completed. On 1/28/16 at 2:00 p.m., an interview was conducted with RN (Registered nurse) # 2, the MDS coordinator. When asked about section D of the MDS she stated, "That was my mistake; the interview should have been attempted. I	F 278		

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F 278	Continued From page 29 should know better." RN #2 stated that she uses the RAI (resident assessment instrument) manual as a reference when completing the MDS. On 1/28/16 at 5:26 p.m., administration was made aware of the above findings. No further information was presented during survey. The RAI (Resident Assessment Instrument) manual documents in part the following under section "D0100: Mood Assessment:" "Coding Instructions: Code 0, no: if the interview should not be conducted. This option should be selected for residents who are rarely/never understood, or who need an interpreter (A1100 = 1) but one was not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©). Code 1, yes: if the resident interview should be conducted. This option should be selected for residents who are able to be understood, and for whom an interpreter is not needed or is present. Continue to item D0200, Resident Mood Interview (PHQ-9©)." 3. The facility staff failed to conduct the interviews for cognition and mood on Resident #5's annual MDS (minimum data set) assessment with an assessment reference date (ARD) 9/10/15; and failed to conduct the interview for mood on the quarterly MDS assessment with ARD 12/10/15. Resident #5 was admitted to the facility on 6/20/14 with diagnoses including, but not limited to: dementia with behaviors, anxiety and major depression. On the most recent MDS, a quarterly assessment with an ARD 12/10/15, Resident #5 was coded as sometimes understood by others (coded as a 2) in Section B0700. A review of the quarterly assessment dated	F 278		

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F 278	Continued From page 30 12/10/15 revealed the resident interview portion of Section C "Cognition" was not completed. Section C-0100 "Should Brief Interview for Mental Status be Conducted?" was coded "No" as evidenced by a "0" in the box for this section (enter "1" for "yes" - continue with resident interview and "0" for "no" - resident is rarely/never understood - skip to and complete....Staff Assessment for Mental Status). The resident was coded as "0" for rarely/never understood. The "Staff Assessment" portion of Section C was completed instead. This conflicted with what was coded in Section B0700 - sometimes understood. A review of the annual assessment dated 9/10/15 revealed the resident interview portion of Section C "Cognition" was not completed. Section C-0100 "Should Brief Interview for Mental Status be Conducted?" was coded "No" as evidenced by a "0" in the box for this section (enter "1" for "yes" - continue with resident interview and "0" for "no" - resident is rarely/never understood - skip to and complete....Staff Assessment for Mental Status). The resident was coded as "0" for rarely/never understood. The "Staff Assessment" portion of Section C was completed instead. This conflicted with what was coded in Section B0700 - sometimes understood. The review of the 9/10/15 annual MDS also revealed the resident interview portion of Section D "Mood" was not completed. Section D-0100 "Should Resident Mood Interview be Conducted?" was coded "No" as evidenced by a "0" in the box for this section (enter "1" for "yes" - continue with resident interview and "0" for "no" - resident is rarely/never understood - skip to and complete....Staff Assessment for Mental Status). The resident was coded as "0" for rarely/never	F 278		

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F 278	Continued From page 31 understood. The "Staff Assessment" portion of Section D was completed instead. This conflicted with what was coded in Section B0700 - sometimes understood. On 1/28/16 at 11:10 a.m., RN (registered nurse) #3, the MDS coordinator, was interviewed regarding these conflicts. When shown the above-referenced portions of the MDS assessments, she stated: "I should have attempted these interviews. I should have coded it that I tried the interviews, but could not finish them because of the resident's abilities on that day. It was an error on my part. I should have said yes to the interviews." On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. No further information was provided prior to exit. 4. For Resident # 12 the facility staff failed to accurately code Section A 1000. Race/Ethnicity on Resident # 12's Quarterly MDS (Minimum Data Set) Assessment with an ARD (Assessment Reference Date) of 12/11/15. Resident # 12 was admitted to the facility on 3/7/11 and readmitted on 12/23/13 with diagnoses that included, but were not limited to: congestive heart failure, seizures, hypertension, depression, macular degeneration, gout, Alzheimer's disease, and arthritis. Resident # 12's most recent MDS (minimum data	F 278		

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F 278	Continued From page 32 set) was a quarterly assessment with an ARD (assessment reference date) of 12/11/15. Resident #12 was coded as being severely impaired for daily decision making. Further review of this MDS revealed in Section A1000 Race/Ethnicity, Resident # 12 was coded as being "Black or African American". Review of Resident # 12's clinical record revealed documentation on the Resident's "Face Sheet" that the Resident was Caucasian. During an interview on 1/28/16 at 11:50 a.m. with RN (Registered Nurse) #2, an MDS Coordinator this MDS assessment was reviewed. RN # 2 was asked about the miscoded race in Section A and RN # 2 after reviewing the MDS responded, "I just clicked on the wrong one." When asked what is used as a guide to complete the MDS RN #2 responded, "We use the RAI (Resident Assessment Instrument) manual." During an interview on 1/28/16 at 4:00 p.m. with ASM (Administrative Staff Member) # 1, the Administrator, and ASM # 3, the Regional Nurse Consultant, these findings were shared. No further information was provided prior to the end of the survey.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	**F-280** **Corrective Action(s):** Resident #11's comprehensive cares plan have been reviewed and revised to reflect the interventions and preventive measures currently in place to prevent falls. A Risk Management Incident & Accident Form was completed for this incident.	

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F 280	Continued From page 33 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. 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 review and revise the comprehensive care plan for two of 26 residents in the survey sample, Residents #11 and #7. 1. The facility staff failed to review and revise Resident #11's comprehensive care plan following a fall on 7/14/15. 2. The facility staff failed to review and revise the comprehensive care plan under the care area "Skin integrity," after a wound was discovered on 12/28/15 for Resident #7. The findings include: 1. Resident #11 was admitted to the facility on 6/15/15 with diagnoses that included but were not limited to: muscle weakness, cardiac arrhythmia (a problem with the rate or rhythm of your	F 280	Resident #7's comprehensive cares plan have been reviewed and revised to reflect the interventions in place for wound care and treatment for a new pressure wound noted. A Risk Management Incident & Accident Form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** Any/all residents who have had a fall or have a wound may have potentially been affected. A 100% review of their comprehensive care plans will be conducted by the RCC and/or designee to identify residents at risk. Residents identified at risk will be corrected at time of discovery and a Risk Management Incident & Accident Form will be completed for each incident identified. **Systemic Changes:** The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant and/or RCC will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in condition.	

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F 280	Continued From page 34 heartbeat*) and low blood pressure. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/24/15, coded the resident's cognitive skills for daily decision making as being severely impaired. Section J documented Resident #11 had not sustained any falls since the prior assessment. Review of Resident #11's clinical record revealed a nurse's note dated 7/14/15 that documented, "At 1130 resident sitting in his w/c (wheel chair) in the day room. Resident tipped his w/c backwards the back of his head was on another residents (sic) w/c wheel....Antitippers (sic) ordered for w/c..." Resident #11's comprehensive care plan with a problem onset date of 6/18/15 failed to document information to reflect the care plan had been reviewed or revised following the fall on 7/14/15. On 1/28/16 at 2:00 p.m., an interview was conducted with RN (registered nurse) #2 (the MDS coordinator who was responsible for updating the care plan). RN #2 stated, "For each fall we must have a different intervention. We update the care plan for each intervention." RN #2 was asked to provide evidence that Resident #11's care plan was reviewed and revised following the 7/14/15 fall. On 1/28/16 at 2:43 p.m., RN #2 confirmed Resident #11's care plan was not updated after the 7/14/15 fall. On 1/28/16 at 5:52 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the	F 280	**Monitoring:** The RCC and DON will be responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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F 280	Continued From page 35 above findings. The facility policy titled, "Using the Care Plan" documented in part, "5. Changes in the resident's condition must be reported to the MDS Assessment Coordinator so that a review of the resident's assessment and care plan can be made..." No further information was presented prior to exit. *This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/arrhythmia.html 2. The facility staff failed to review and revise the comprehensive care plan under the care area "Skin integrity," after a wound was discovered on 12/28/15 for Resident #7. Resident #7 was admitted to the facility on 8/4/15 and readmitted on 12/11/15 with diagnoses that included but not limited to high blood pressure, type two diabetes, stroke, dysphagia (difficulty swallowing), severe peripheral vascular disease and muscle weakness. Resident #7's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 12/18/15. The resident was coded as never understanding others and never being understood by others for communication. Resident #7 was coded as being severely impaired in the ability to make daily decisions. The resident was coded as being totally dependent on staff with transfers, dressing, eating, personal hygiene and bathing.	F 280		

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F 280	Continued From page 36 Review of Resident #7's clinical record revealed a wound assessment report dated 12/28/15. This report documented in part, the following: "Wound Type: Pressure, Wound Location: Left Lateral Malleolus, Wound Status: unchanged, Date wound identified: 12/28/15..." Resident #7's care plan dated 12/18/15 documented the following: "Nursing Dx (diagnosis): Skin integrity, risk for impaired Problem onset: Potential for skin breakdown due to incontinence. Goal and Target date: Pressure ulcer will show signs or healing (decrease in size) by next review) Maintain intact skin integrity thru next review. Approaches: Provide treatments as ordered, turn and reposition resident q (every) 2 hours, float resident heels while in bed, staff to measure and document on pressure areas as ordered, air loss mattress to bed, cleanse perineal area after each incontinent episode." Review of Resident #7's care plan dated 12/18/15 revealed that interventions were put in place for skin integrity prior to the development of the 12/28/15 pressure ulcer. Interventions were not updated on the care plan after the development of the ulcer on 12/28/15. There was no evidence that the care plan was reviewed after the development of the ulcer. Review of the wound care specialist notes revealed an order dated 12/28/15 that documented the following: "Dry protective dressing-Once daily, Balsum Peru/Trypsin Spray.** Review of the 1/2016 TAR (treatment administration record) revealed that this order	F 280		

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F 280	Continued From page 37 had been implemented by nursing staff. On 1/28/16 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the MDS (minimum data set) coordinator. When asked the process of revising the care plan she stated, "We initiate a care plan when the resident is admitted to the facility and then we revise during any change in the resident's condition." When asked who is responsible for updating the care plan, LPN #1 stated that nursing will communicate to MDS any changes in the resident's condition. MDS will then determine appropriate interventions for that resident. When asked the process of updating the care plan after a resident obtains a pressure ulcer she stated, "We get the treatment orders from the doctor and then we will write the wound and orders on the care plan." LPN #1 reviewed Resident #7's care plan and stated, "Well the care plan says pressure in the goal and target date; I didn't know we had to be specific when identifying the wounds." When shown that the interventions were put in place prior to the development of the pressure ulcer on 12/28/16, LPN #1 stated, "Like I said I didn't know we had to be specific and document every pressure." LPN #1 stated that she uses the RAI (Resident assessment Instrument) manual to help assist with completing the care plan. On 1/28/16 at 5:26 p.m., administration was made aware of the above findings. No further information was provided during survey. Facility policy titled, "Using the Care Plan," in part, documents the following: "...4. Other facility staff noting a change in the resident's condition must also report those	F 280		

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F 280	Continued From page 38 changes to the nurse supervisor and/or the MDS Assessment Coordinator. 5. Changes in the resident's condition must be reported to the MDS Assessment Coordinator so that a review of the resident's assessment and care plan can be made. 6. Documentation must be consistent with the resident's care plan." *Balsum Peru/Trypsin Spray: "Wound treatment that relieves pain and promotes healing; stimulates blood vessel activity and debrides eschar and necrotic tissue." This information was obtained from http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=06ec7e77-2fbf-4722-94d8-2c083a1759b3.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. 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 professional standards of practice for three of 26 residents in the survey sample, (Resident # 4, # 6 and # 7). 1. For Resident # 4 the facility staff failed to develop an interim care plan to meet the Resident's needs after Resident # 4 was readmitted to the facility. Resident # 4 had a Foley catheter, a colostomy, and a pressure wound.	F 281	**F281** **Corrective Action(s):** Resident #4's attending physician has been notified that the facility staff failed to develop and interim care plan for resident #4 after readmission. Resident #4 now has a comprehensive care plan completed. A Facility Incident & Accident Form was completed for this incident. Resident #6's attending physician has been notified that the facility staff failed to accurately document the resident's allergy to Bactrim. Resident #6's clinical record and immunization records have been updated to reflect the resident's allergy to Bactrim. A Facility Incident & Accident Form was completed for this incident.	

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F 281	Continued From page 39 2. The facility staff failed to ensure the allergy sticker and immunization record contained in Resident # 6's clinical record accurately documented the Resident's allergy. 3. Facility staff failed to accurately transcribe hospital discharge orders dated 12/12/15 and Resident #7 received unnecessary dressing changes for December 2015 and January 2016. The findings include: 1. Resident # 4 was admitted to the facility on 7/29/14, readmitted on 6/1/15 and again readmitted on 1/26/16 with diagnoses that included, but were not limited to: diabetes, hypertension, hyperlipidemia, dementia, depression, glaucoma, gastroesophageal reflux disease, coronary artery disease, and benign prostatic hypertrophy. Resident # 4's most recent MDS (minimum data set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/7/15. Resident # 4 was coded as an 8 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was cognitively impaired. Section H "Bladder and Bowel H0100 " documented that Resident # 4 had " A. Indwelling catheter & C. Ostomy (including urostomy, ileostomy, colostomy). Section M "Skin Conditions M0300" documented that Resident # 4 had "D. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle." Review of Resident # 4's clinical record revealed documentation on the Resident's Face Sheet that the Resident was readmitted on 1/26/16 at 2:00	F 281	Resident #7's attending physician has been notified that the facility staff failed to accurately transcribe the resident's hospital discharge orders resulting in unnecessary dressing changes. Resident #7's physician orders have been reviewed to ensure all medication and treatment orders are correctly written and transcribed. A Facility Incident & Accident Form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all resident medication and treatment orders, Allergies and care plans, to include the presence of interim care plans for new admissions to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physician will be notified of each incorrect medication order. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of the plan care which includes, obtaining, transcribing and administering physician ordered medications and treatments, revising and completing interim care	

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F 281	Continued From page 40 a.m.; further review revealed a nurse's note dated 1/26/16 at 2:50 a.m., "Pt (patient) returned the (name of facility) facility at 2am transported by Ambulance services ...Foley cath (catheter) intact and patent, draining qs (quantity sufficient). No signs of bleeding noted. Colostomy intact with no signs of bleeding ..." A review of the unit care plan book revealed that there was no care plan for Resident # 4. During an interview on 1/28/16 at 1:45 p.m. with RN (Registered Nurse) # 6, the Unit Manager, a request was made for Resident # 4's care plan. RN # 6 presented a "discharge folder" that contained the care plan with a date of 12/7/15. When RN # 6 was asked why the care plan was in this folder; RN # 6 stated that Resident # 4 went out to the emergency room on 1/25/16 and did not return until after midnight so he was considered a new admission and everything was pulled. RN # 6 stated that she was new but she thought that a new care plan should be done. LPN (Licensed Practical Nurse) # 1, an MDS Coordinator, was in the hallway and RN # 6 asked LPN #1 if Resident # 4 should have another care plan. LPN # 1 replied, "Yes, he should." As of 1/28/16 at 2:00 p.m. there was no interim care plan to address the above care needs for Resident # 4. RN # 6 stated, "I will do one now." A copy of the completed care plan was requested at this time. The completed "Interim Plan of Care" was presented by RN # 6 on 1/28/16 at 2:30 p.m. During an interview on 1/28/16 at 4:00 p.m. with	F 281	plans and accurate allergy alerts. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the procedure for obtaining and transcribing physician medication & treatment orders, revising and completing interim care plans and ensuring that correct allergy information is contained in the medical records. **Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will performs chart audits weekly coinciding with the care plan calendar in order to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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F 281	Continued From page 41 ASM (Administrative Staff Member) # 1, the Administrator, and ASM # 3, the Regional Nurse Consultant, these findings were shared. A request for the facility policy on interim care plans was made. Review of the facility policy: "Care Plans---Preliminary" documented the following: "A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission." According to "Fundamentals of Nursing Made Incredibly Easy" Lippincott Williams and Wilkins, Philadelphia PA page 56: "The first step in the nursing process--assessment--begins when you first see the patient. According to the American Nurses Association guidelines, data should accurately reflect the patient's life experiences, and his patterns of living...during the assessment you collect relevant information from various sources and analyze it to form a complete picture of your patient...It guides you through the rest of the nursing process, helping you formulate nursing diagnoses, expected outcomes, and nursing interventions. It serves as a vital communication tool for other team members- as a baseline for evaluating a patient's progress and for use as legal documentation...the initial assessment helps you determine what care the patient needs and sets the stage for further assessments...the history of the patient as well as medical problems are of great importance..." and on page 65, "A written care plan serves as a communication tool among health care team members that helps ensure the continuity of care...the care plan is developed on admission and includes the most significant problems and is	F 281		

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F 281	Continued From page 42 reviewed and revised as necessary..." 2. The facility staff failed to ensure the allergy sticker and immunization record contained in Resident #6's clinical record accurately documented the resident's allergy. Resident #6 was admitted to the facility on 10/23/14 with diagnoses that included but were not limited to: anxiety disorder, muscle weakness and high blood pressure. Resident #6's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/22/15, coded the resident as being cognitively intact (scoring a 15 out of a possible 15 on the Brief Interview for Mental Status). Review of Resident #6's clinical record revealed a nurse's note dated 12/3/15 that documented, "(Name of nurse practitioner) in and evaluated rash on left leg and rash has spread to forehead and right leg. See new orders..." A physician's order dated 12/3/15 documented, "Consult urologist in AM to order new antibiotic. D/C (Discontinue) Bactrim- Allergic Reaction-Rash..." Physician order summaries signed by the physician prior to 12/3/15 documented no known drug allergies; however, Resident #6's most recent physician's order summary signed by the physician on 1/8/16 documented, "Allergies: Bactrim." An allergy sticker attached to the inside of the front cover of Resident #6's clinical record documented, "Allergic: NKA (No Known	F 281		

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F 281	Continued From page 43 Allergies)." Resident #6's immunization record documented, "Allergies: NKDA (No Known Drug Allergies)." Resident #6's comprehensive care plan with a problem onset date of 10/31/14 documented, "Potential for injury. Goal & Target Date: Have no injury related to medication usage/side effects by next review. Approaches: Administer medication as ordered by physician; observe resident for any adverse side effects and document..." On 1/28/16 at 2:45 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated a resident's allergies are documented on the label (RN #3 pointed to the allergy sticker located in Resident #6's clinical record), the immunization record and the admission order sheet. When asked what should be done if a resident is newly diagnosed with an allergy, RN #3 stated the allergy should be put on the label, entered into the computer, noted on the MAR (Medication Administration Record) and put in a nurse's note. RN #3 stated a resident's allergies are documented everywhere in the clinical record so you would have a lot of places to look and if an allergy is newly diagnosed then everything should be updated. On 1/28/16 at 5:52 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. A policy regarding documentation of allergies was requested. ASM #2 was asked if the facility followed a certain standard of practice regarding documentation of allergies and stated the facility did not.	F 281		

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F 281	Continued From page 44 Potter and Perry, Fundamentals of Nursing, 6th edition, p. 843: "A client has the following rights: To have qualified nurses or physicians assess a medication history, including allergies." No further information was presented prior to exit. 3. The facility staff failed to accurately transcribe hospital discharge orders dated 12/12/15 and documentation in Resident #7's clinical record revealed Resident #7 received unnecessary dressing changes during December 2015 and January 2016. Resident #7 was admitted to the facility on 8/4/15 and readmitted on 12/11/15 with diagnoses that included but not limited to high blood pressure, type two diabetes, stroke, dysphagia (difficulty swallowing), severe peripheral vascular disease and muscle weakness. Resident #7's most recent MDS (minimum data set) was a significant change assessment with an ARD of 12/18/15. The resident was coded as never understanding others and never being understood by others for communication. Resident #7 was coded as being severely impaired in the ability to make daily decisions. The resident was coded as being totally dependent on staff with transfers, dressing, eating, personal hygiene and bathing. Review of Resident #7's clinical record revealed a wound care specialist evaluation assessment dated 9/18/15 that documented the following: "Stage 3 pressure wound of the sacrum (Resolved on 9/18/15)." This wound was discovered on 8/28/15 and treatments were put into place.	F 281		

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F 281	Continued From page 45 Further review of the clinical record revealed the September 2015 TAR (Treatment Administration Record) that documented the following: "Cleanse sacrum with DWC, apply Santyl* ointment and apply 4X4 allevyn** qd (every day)." This order was initiated on 9/10/15 and discontinued on 9/18/15 (the resolve date of the wound). Resident #7's clinical record revealed that she went to the hospital on 12/6/15 for pneumonia. Resident #7 arrived back to the facility on 12/11/15. Review of the physician order sheet dated 1/15/16 revealed an order that documented the following: "Cleanse sacral area with DWC, apply skin prep periwound, apply santyl, and allevyn QD (everyday)." This order was discontinued on 1/28/16, the day of survey. Review of the December 2015 and January 2016 TARS (treatment administration record) revealed that Resident #7 had been receiving this treatment every day from 12/12/15 until 1/28/15 (the day the order was discontinued). On 1/28/15 at 4:45 p.m., wound care observation was conducted. Resident #7's skin on her sacrum was intact. No wound or breakdown was noted to this area. On 1/28/15 at 4:21 p.m., an interview was conducted with RN (Registered Nurse) #6, the unit manager. When asked about the sacral wound order she stated that the order was somehow written when the Resident returned back from the facility on 12/12/15. When asked who is responsible for transcribing hospital	F 281		

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F 281	Continued From page 46 discharge orders she stated," The unit managers, so me." When asked if this order was on the hospital discharge orders she stated, "No. The order just came over when it shouldn't have." When asked the process of transcribing orders she stated that she writes all the orders that are on the discharge list and reviews the orders to ensure medications are correct. When asked who is responsible for transcribing admission orders on weekends or night shifts she stated, "Our admissions only come during the day and week when the supervisors are here." When asked if Resident #7 had a sacral wound after 9/18/15 (date of resolve date) she stated, "No. I don't know what had happened; her bottom had not been bad." Other nurses working on 3-11 shift for the month of December 2015 and January 2016 with Resident #7 could not be reached for an interview. On 1/28/15 at 4:30 p.m., administration was made aware of the above concerns. No further information was presented during the time of survey. The facility policy titled, "Physician Medication Orders", did not address accurately transcribing orders. The following information is provided in Basic Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 349-360) was used as a reference for medication administration. A medication order is required for you to administer any medication to a patient. Once you receive and process a medication,	F 281		

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F 281	Continued From page 47 place the physician's or health care provider's complete order on the appropriate medication form, the MAR. The MAR includes the patient's name, room, and bed number, as well as the names, dosages, frequencies, and routes of administration for each medication. When transcribing orders, ensure the names of medications, dosages, routes, and times are legible. The nurse checks all orders for accuracy and thoroughness. When orders are transcribed, the same information needs to be checked again by the nurse. It is essential that you verify the accuracy of every medication you give to the patient with the patient's orders. To ensure safe medication administration, be aware of the six rights of medication administration. 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation *Santyl ointment is an ointment that is applied directly to the wound and digests collagen in necrotic (dead) tissue. Use of Santyl should be terminated when debridement of necrotic tissue is complete and granulation is well established. This information was obtained from http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a7bf0341-49ff-4338-a339-679a3f3f953d. ** Allevyn- waterproof dressing that requires no additional tape or bandage. Suitable for exuding wounds (wounds with drainage). This information was obtained from http://www.ncbi.nlm.nih.gov/pubmed/8845677.	F 281		

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	495353	A. BUILDING _____ B. WING _____	C 01/29/2016

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the plan of care for one of 26 residents in the survey sample, Resident #15. The facility staff failed to consistently follow the care plan for assessing the *bruit and *thrill of Resident #15's hemodialysis **AV fistula on multiple occasions during December 2015 and January 2016. *"A bruit is an audible vascular sound associated with turbulent blood flow. Although usually heard with the stethoscope, such sounds may occasionally also be palpated as a thrill." This information is taken from the website http://www.ncbi.nlm.nih.gov/books/NBK289/. **"In hemodialysis, a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately...Arteriovenous (AV) fistula. A surgically created AV fistula is a connection between an artery and a vein, usually in the arm you use less often. This is the preferred type of access because of effectiveness and safety." This information is taken from the website http://www.mayoclinic.org/tests-procedures/hemodialysis/basics/results/prc-20015015.	F 282	**F282** **Corrective Action(s):** Resident #15's attending physician has been notified that facility staff failed to assess the resident's Hemodialysis AV shunt for Bruit and Thrill, bleeding and did not obtain pre and post dialysis vital signs per plan of care. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents who receive dialysis may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all residents receiving dialysis to identify residents at risk for inconsistent/inappropriate monitoring. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physician will be notified of each incident. **Systemic Change(s):** The facility policy and procedure for dialysis care and management has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all Licensed Nursing staff regarding proper pre and post dialysis monitoring and treatment to be performed every shift.	

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F 282	Continued From page 49 The findings include: Resident #15 was admitted to the facility on 1/7/15 with diagnoses including, but not limited to: end stage kidney disease, heart disease and diabetes. On the most recent MDS (minimum data set), an annual assessment with assessment reference date (ARD) 1/13/16, Resident #15 was coded as having no cognitive impairment for making daily decisions, having scored 13 out of 15 on the Brief Interview for Mental Status (BIMS). Resident #15 was coded as having received dialysis services during the look back period. On 1/28/16 at 4:00 p.m., Resident #15 was observed sitting in a chair in her room. When asked about her dialysis services, she stated that she goes out to dialysis three times a week. When asked if she would show the surveyor her access site, she showed the surveyor her left arm, and pointed out the AV fistula located mid-way up her arm. When asked how often the staff checks her access site, she stated: "Sometimes. Not usually." When asked if the staff takes her vital signs when she initially returns from her dialysis appointments, she stated: "Same thing. Not usually." A review of the physician's orders for Resident #15 revealed, in part, the following: "Fluid restriction 1200 cc (cubic centimeters)/day - Document in nurses notes...Dialysis MWF (Monday Wednesday Friday) at [name of local dialysis provider]." These orders were written 3/18/15 and most recently signed by the physician on 1/12/16. A review of the orders did not reveal any instructions related to the care of	F 282	**Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON, and/or Unit Manager will review documentation on all residents who receive dialysis weekly to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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F 282	Continued From page 50 the dialysis site or taking vital signs after the resident returned from dialysis. A review of the MARs (medication administration records) and TARs (treatment administration records) for Resident #15 for December 2015 and January 2016 revealed no evidence that the facility staff was assessing the resident's dialysis access site. A review of the nurses notes for Resident #15 revealed evidence that the staff assessed the bruit and thrill of the access site only on the following dates: 12/1/15 at 2:12 p.m.; 12/5/15 at 2:57 p.m.; 12/7/15 at 2:26 a.m.; 12/8/15 at 4:03 a.m.; 12/12/15 at 2:02 a.m.; 12/14/15 at 2:04 a.m.; 12/15/15 at 2:48 p.m.; 12/16/15 at 11:16 p.m.; 12/20/15 at 3:09 a.m. and 2:52 p.m.; 12/22/15 at 2:17 a.m.; 1/3/16 at 3:29 p.m.; 1/6/16 at 4:48 p.m.; 1/8/16 at 2:28 a.m.; 1/14/16 at 2:52 a.m.; 1/15/16 at 10:04 p.m.; 1/16/16 at 2:57 a.m.; and 1/18/16 at 11:18 p.m. A review of the comprehensive care plan for Resident #15 dated 1/30/15 revealed, in part, the following: "Will receive dialysis as scheduled without complications through next review...Check left arm dialysis shunt before and after each dialysis treatment." On 1/29/16 at 8:50 a.m., LPN (licensed practical nurse) #3 was interviewed regarding care of residents receiving dialysis. She stated: "We usually have them on a fluid restriction. We have to check their dialysis site for bruits." When asked when the staff is to check the site for bruits, she stated: "When she comes back from dialysis." When asked where this assessment would be documented, she stated: "In the nurses	F 282		

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F 282	Continued From page 51 notes." When asked if she was aware of what Resident #15's care plan called for, she stated: "No. I would have to look it up." On 1/29/16 at 9:10 a.m., LPN #2, the unit manager for Resident #15, was interviewed regarding care of residents receiving dialysis. She stated: "We document intake and output. We get their vitals when they return from dialysis." When asked where the vital signs are documented, she stated: "In the nurses notes." She further stated that the nurses also document the thrill and bruit at the access site when the resident returns from dialysis. She stated this documentation also happens in the nurses notes. LPN #2 was shown the nurses notes, MARs and TARs for Resident #15 for December 2015 and January 2016. She was asked if the assessments she had described were documented consistently in the nurses notes. She stated: "No." When asked if the facility staff had performed the assessments she had described, she stated: "If it's not in the nurses notes, then I would say no." A review of the facility policy entitled "End-Stage Renal Disease, Care of a Resident With" revealed, in part, the following: "Staff caring for residents with ESRD (End Stage Renal Disease), including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically: The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis...The care of grafts and fistulas...Education and training of staff in the care of ESRD/dialysis residents may be managed by the contracted dialysis facility or by a clinician with special	F 282		

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F 282	Continued From page 52 training in ESRD and dialysis care..." A review of the facility policy entitled "Dialysis Protocol" revealed no information related to assessment of residents receiving dialysis services. A review of the facility policy entitled "Using the Care Plan" revealed, in part, the following: "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have the responsibility for providing care or services to the resident...Completed care plans are placed in the resident's chart and/or in a 3-ring binder located at the appropriate nurses ' station...Documentation must be consistent with the resident's care plan." On 1/26/16 at 9:50 a.m., RN (registered nurse) #6 was interviewed regarding the care of residents receiving dialysis services. She stated: "We monitor vital signs, intake and outputs, weights, scheduled labs (laboratory tests)." When asked if she could think of anything else that would need to be assessed, she stated: "Nope. That's it." When she was asked if she was aware of what Resident #15's care plan stated regarding the dialysis care, she stated: "No. I'd have to look to see." On 1/26/16 at 9:55 a.m., RN #8 was interviewed regarding the care of residents receiving dialysis services. She stated: "When they get back from dialysis, we check for thrill and bruit. We make sure we document on them in the nurses notes. We also document on their fluid restriction." When she was asked if she was aware of what Resident #15's care plan stated regarding the	F 282		

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F 282	Continued From page 53 dialysis care, she stated: "Not right now." On 1/26/16 at 10:00 a.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns. No further information was provided prior to exit. Medical Surgical Nursing Made Incredibly Easy, Lippincott Williams & Wilkins copyright 2004, page 565, Dialysis Monitoring and Aftercare: "After completion of hemodialysis, monitor the vascular access site for bleeding. If bleeding is excessive, maintain pressure on the sited and notify the doctor ...To prevent clotting or other problems with blood flow, make sure that the arm used for vascular access isn't used for any other procedure, including I.V. line insertion, blood pressure monitoring, and venipuncture ...At least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site doe dialysis my indicated a blood clot requiring immediate surgical attention."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	**F309** **Corrective Action(s):** Residents #15's attending physician was notified that the facility failed to follow written protocols and policies specific for rendering the care of dialysis patients. A facility Incident and Accident form was completed for this incident.	

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F 309	Continued From page 54 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide dialysis-related services for one of 26 residents in the survey sample, Resident #15. The facility staff failed to consistently assess the *bruit and *thrill of Resident #15's hemodialysis **AV fistula, and to consistently obtain vital signs on the resident when she returned from dialysis on multiple occasions during December 2015 and January 2016. *"A bruit is an audible vascular sound associated with turbulent blood flow. Although usually heard with the stethoscope, such sounds may occasionally also be palpated as a thrill." This information is taken from the website http://www.ncbi.nlm.nih.gov/books/NBK289/. **"In hemodialysis, a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately...Arteriovenous (AV) fistula. A surgically created AV fistula is a connection between an artery and a vein, usually in the arm you use less often. This is the preferred type of access because of effectiveness and safety." This information is taken from the website http://www.mayoclinic.org/tests-procedures/hemodialysis/basics/results/prc-20015015. The findings include: Resident #15 was admitted to the facility on 1/7/15 with diagnoses including, but not limited to: end stage kidney disease, heart disease and diabetes. On the most recent MDS (minimum	F 309	**Identification of Deficient Practices/Corrective Action(s):** All other residents receiving dialysis may have been potentially affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all Dialysis residents' physician orders and MAR's to identify residents at risk for not receiving physician ordered pre and post dialysis monitoring and communication from the dialysis center for all residents receiving dialysis. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record / physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician medication orders, treatment orders and the pre and post dialysis monitoring and communication. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. This inservice will also include pre and post dialysis monitoring and communication per physician orders.	

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F 309	Continued From page 55 data set), an annual assessment with assessment reference date (ARD) 1/13/16, she was coded as having no cognitive impairment for making daily decisions, having scored 13 out of 15 on the Brief Interview for Mental Status (BIMS). She was coded as having received dialysis services during the look back period. On 1/28/16 at 4:00 p.m., Resident #15 was observed sitting in a chair in her room. When asked about her dialysis services, she stated that she goes out to dialysis three times a week. When asked if she would show the surveyor her access site, she showed the surveyor her left arm, and pointed out the AV fistula located mid-way up her arm. When asked how often the staff checks her access site, she stated: "Sometimes. Not usually." When asked if the staff takes her vital signs when she initially returns from her dialysis appointments, she stated: "Same thing. Not usually." A review of the physician's orders for Resident #15 revealed, in part, the following: "Fluid restriction 1200 cc (cubic centimeters)/day - Document in nurses notes...Dialysis MWF (Monday Wednesday Friday) at [name of local dialysis provider]." These orders were written 3/18/15 and most recently signed by the physician on 1/12/16. A review of the orders did not reveal any instructions related to the care of the dialysis site or taking vital signs after the resident returned from dialysis. A review of the resident's chart revealed the presence of a document taped to the front of the chart. The document contained the resident's name in the top left corner and was entitled "Nursing Care for Dialysis Residents." Review of	F 309	**Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will audit all dialysis residents Pre and Post dialysis monitoring and communication weekly to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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F 309	Continued From page 56	F 309		

this document revealed, in part, the following: "When the patient returns from dialysis, assess his access site for bleeding and make sure his bp (blood pressure) is stable before letting him resume activity...Assess the thrill and bruit of the access site each shift. If they're absent, notify the MD and the dialysis nurse and document this information in the nurses ' notes. (Feel the thrill, hear the bruit.)"

A review of the MARs (medication administration records) and TARs (treatment administration records) for Resident #15 for December 2015 and January 2016 revealed no evidence that the facility staff was assessing the resident's dialysis access site.

A review of the nurses notes for Resident #15 revealed evidence that the staff assessed the bruit and thrill of the access site only on the following dates: 12/1/15 at 2:12 p.m.; 12/5/15 at 2:57 p.m.; 12/7/15 at 2:26 a.m.; 12/8/15 at 4:03 a.m.; 12/12/15 at 2:02 a.m.; 12/14/15 at 2:04 a.m.; 12/15/15 at 2:48 p.m.; 12/16/15 at 11:16 p.m.; 12/20/15 at 3:09 a.m. and 2:52 p.m.; 12/22/15 at 2:17 a.m.; 1/3/16 at 3:29 p.m.; 1/6/16 at 4:48 p.m.; 1/8/16 at 2:28 a.m.; 1/14/16 at 2:52 a.m.; 1/15/16 at 10:04 p.m.; 1/16/16 at 2:57 a.m.; and 1/18/16 at 11:18 p.m.

A review of the nurses notes for Resident #15 revealed evidence that the staff assessed her vital signs when she returned from dialysis only on the following dates: 12/2/15 at 6:04 p.m.; 12/14/15 at 9:25 p.m.; 1/6/16 at 4:48 p.m.; 1/13/16 at 11:25 p.m.; 1/15/16 at 10:04 p.m.; 1/18/16 at 11:18 p.m.; and 1/20/16 at 10:38 p.m.

A review of the comprehensive care plan for

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F 309	Continued From page 57 Resident #15 dated 1/30/15 revealed, in part, the following: "Will receive dialysis as scheduled without complications through next review...Check left arm dialysis shunt before and after each dialysis treatment." On 1/29/16 at 8:50 a.m., LPN (licensed practical nurse) #3 was interviewed regarding care of residents receiving dialysis. She stated: "We usually have them on a fluid restriction. We have to check their dialysis site for bruits." When asked when the staff is to check the site for bruits, she stated: "When she comes back from dialysis." When asked where this assessment would be documented, she stated: "In the nurses notes." On 1/29/16 at 9:10 a.m., LPN #2, the unit manager for Resident #15, was interviewed regarding care of residents receiving dialysis. She stated: "We document intake and output. We get their vitals when they return from dialysis." When asked where the vital signs are documented, she stated: "In the nurses notes." She further stated that the nurses also document the thrill and bruit at the access site when the resident returns from dialysis. She stated this documentation also happens in the nurses notes. LPN #2 was shown the nurses notes, MARs and TARs for Resident #15 for December 2015 and January 2016. She was asked if the assessments she had described were documented consistently in the nurses ' notes. She stated: "No." When asked if the facility staff had performed the assessments she had described, she stated: "If it's not in the nurses notes, then I would say no." When asked about the paper taped to the front of the chart, she stated: "I don't know where it came from or what	F 309		

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F 309	Continued From page 58 it is. I will have to check." LPN #2 returned to the surveyor at 9:25 a.m. and stated: "[The assistant director of nursing] had just printed it off. It is not our protocol." When asked where the document originated, she stated: "[The assistant director of nursing] just printed it off." When asked why it contained the resident's name and was taped to the front of the resident's chart, she stated: "It's not there anymore." LPN #2 was asked to provide the surveyor with facility policies and procedures regarding dialysis care. A review of the facility policy entitled "End-Stage Renal Disease, Care of a Resident With" revealed, in part, the following: "Staff caring for residents with ESRD (End Stage Renal Disease), including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically: The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis...The care of grafts and fistulas...Education and training of staff in the care of ESRD/dialysis residents may be managed by the contracted dialysis facility or by a clinician with special training in ESRD and dialysis care..." A review of the facility policy entitled "Dialysis Protocol" revealed no information related to assessment of residents receiving dialysis services. On 1/26/16 at 9:45 a.m., LPN #2 was asked to provide evidence of education provided to staff regarding the care and special needs of residents receiving dialysis. She stated: "We don't have any evidence or inservices. But we will."	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495353	A. BUILDING _____ B. WING _____	C 01/29/2016

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F 309	Continued From page 59 On 1/26/16 at 9:50 a.m., RN (registered nurse) #6 was interviewed regarding the care of residents receiving dialysis services. She stated: "We monitor vital signs, intake and outputs, weights, scheduled labs." When asked if she could think of anything else that would need to be assessed, she stated: "Nope. That's it." When asked if the facility had provided any training regarding dialysis services and resident assessment, she stated: "No. It's just what we know from nursing school." On 1/26/16 at 9:55 a.m., RN #8 was interviewed regarding the care of residents receiving dialysis services. She stated: "When they get back from dialysis, we check for thrill and bruit. We make sure we document on them in the nurses notes. We also document on their fluid restriction." When asked if the facility had provided any training regarding dialysis services and resident assessment, she stated: "I do my own education - reading publications online." On 1/26/16 at 10:00 a.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns. No further information was provided prior to exit. Medical Surgical Nursing Made Incredibly Easy, Lippincott Williams & Wilkins copyright 2004, page 565, Dialysis Monitoring and Aftercare: "After completion of hemodialysis, monitor the vascular access site for bleeding. If bleeding is excessive, maintain pressure on the sited and notify the doctor ...To prevent clotting or other problems with blood flow, make sure that the arm used for vascular access isn't used for any other procedure, including I.V. line insertion, blood	F 309		

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F 309	Continued From page 60 pressure monitoring, and venipuncture ...At least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site doe dialysis my indicated a blood clot requiring immediate surgical attention."	F 309		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. 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 provide services to meet the psychosocial needs of two of 26 residents in the survey sample, Residents #9 and #14. 1. The facility staff failed to provide a psychological consult for Resident #9 as ordered by the physician. 2. The facility staff failed to follow-up on further psychological services recommended by a provider for Resident #14. The findings include: 1. Resident #9 was admitted to the facility on 10/7/11 with diagnoses including, but not limited	F 319	**F319** **Corrective Action(s):** Resident #9 has been assessed by the psychologists and attending physician to assess his current needs and behaviors to establish an appropriate plan of treatment to meet his psychosocial needs. His comprehensive care plan has been revised to reflect the current approaches and interventions in his plan of care. Resident #14 has been assessed by the psychologists and attending physician to assess his current needs and behaviors to establish an appropriate plan of treatment to meet his psychosocial needs. His comprehensive care plan has been revised to reflect the current approaches and interventions in his plan of care.	

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F 319	Continued From page 61 to: history of a stroke with paralysis on one side of his body; dementia, psychosis, and major depression. On the most recent MDS (minimum data set), a significant change assessment with assessment reference date (ARD) 10/28/15, he was coded as being moderately impaired for making daily decisions, having scored eight out of ten on the BIMS (brief interview for mental status. He was coded as having demonstrated exit-seeking behaviors during the look back period. A review of the clinical record for Resident #9 revealed the following physician's order, written 4/1/15: [Name of mental health services provider] to eval (evaluate) and treat." Further review of the clinical record revealed no evidence that this order had been followed. On 1/28/16 at 9:20 a.m., ASM (administrative staff member) #1, the administrator, was asked to provide the surveyor with evidence of all psychological/mental health consults for Resident #9. On 1/28/16 at 1:20 p.m., OSM (other staff member) #3, the social worker, approached the surveyor and gave her a copy of a document with the above-referenced mental health services provider's letterhead. The document was dated 1/28/16. Review of this document revealed, in part, the following: "To Whom It May Concern: On April 24, 2015, we received a referral from [name of facility] to see [Resident #9] for Mental Health Services. Our Intake Department determined this patient was not eligible for our service due to not having Medicare Part B." The document was signed by an executive vice	F 319	**Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who display psychosocial needs/difficulties may have been potentially affected. The DON, ADON or Unit Managers will conduct 100% review of all residents receiving psychiatric treatment and follow up to identify residents at risk. Residents identified at risk will have their current needs and behaviors assessed by their attending physician and/or psychiatrist to establish appropriate treatment interventions. An incident & accident form will be completed for each incident. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The DON, Unit Managers and/or RCC will review the 24-hour report daily to insure that each resident's current medical needs including their psychosocial needs are being addressed in a timely manner to ensure that appropriate medical and psychological interventions are being obtained as ordered. All negative findings will be reported to administrator for immediate corrective action. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform chart audits weekly coinciding with the Care Plan calendar to monitor for compliance. Detailed findings of the audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for	

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F 319	Continued From page 62 president of the mental health services company. OSM #3 stated: "They did not see him because they do not accept his insurance." When asked what the facility staff had done to arrange for another mental health services provider for Resident #9, OSM #3 stated: "I don't believe they ever put him on the list to be seen by the psychologist who comes here to see residents." OSM #3 stated: "I only started here July first (2015). They did not communicate with me that he needed anything." When asked whose job it is to make sure residents receive needed mental health services, she stated: "I guess it's my job to follow up and make sure it's done. I'll have them put him on the list." A review of the comprehensive care plan for Resident #9 dated 10/7/11 and updated 10/28/15, revealed, in part, the following: "Continued care by facility staff per PCP (primary care physician) and physician orders...Will observe for moods/behaviors and psychosocial needs." On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. Policies and procedures regarding mental health services were requested. On 1/29/16 at 8:10 a.m., ASM #1 stated: "We don't have that kind of policy. We do have a job description for the social worker." A review of the document entitled "Social Services Director" revealed, in part, the following: "The Social Services Director plans, organizes, and directs programs that facilitate the social, psychological, and physiological well-being of each	F 319	change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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F 319	Continued From page 63 resident...Assume responsibility for referral of residents to social, health, and community agencies. Document referrals in resident records." No further information was provided prior to exit. 2. Resident #14 was admitted to the facility on 7/15/14 and most recently readmitted on 12/21/15 with diagnoses including, but not limited to: *Asperger syndrome, **schizophrenia and diabetes. On the most recent MDS, a significant change assessment with ARD 12/28/15, Resident #14 was coded as having scored 15 out of 15 on the BIMS. He was coded as having disorganized thinking, as having verbal behaviors directed toward others during the look-back period. A review of the physician's orders for Resident #14 revealed the following order written 12/21/15: "[Name of mental health services provider] to eval (evaluate) and treat for behavioral health services." Further review of the clinical record revealed a consult note from the mental health service provider dated 7/23/15. A review of this note revealed, in part, the following: "TREATMENT PLAN: Problem: Depression. Plan: Pt (patient) refuses meds (medications) but is willing to get talk therapy...Offer therapy services/refer to Psychology...Discharge from my clinic as refusing meds but is willing to get psychotherapy and is very gregarious (talkative)." On 1/28/16 at 1:20 p.m., OSM (other staff member) #3, the social worker, was interviewed regarding the recommendation for further	F 319		

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F 319	Continued From page 64 psychotherapy for Resident #14. She stated: "I just missed it." When asked what the process is for providing residents with psychotherapy as recommended by providers, she stated: "I receive the notes from [name of evaluating agency]. Then I give a copy to the unit and I keep a copy to follow up on. I just missed this. I guess I need to put him on the list for [name of psychologist who provides services at the facility]." She explained that the provider who recommended the further therapy for Resident #14 only does evaluations remotely - that is, the evaluator is not on facility property and the evaluation is done long-distance via computer technology. She stated the evaluator and the resident are able to see each other and converse by way of computer screens. A review of the comprehensive care plan for Resident #14 dated 12/28/15 revealed, in part, the following: "Observe for changes in mental status. Provide consistent caregiver. " On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. *"Asperger syndrome (AS) is a developmental disorder. It is an autism spectrum disorder (ASD), one of a distinct group of neurological conditions characterized by a greater or lesser degree of impairment in language and communication skills, as well as repetitive or restrictive patterns of thought and behavior." This information is taken from the website http://www.ninds.nih.gov/disorders/asperger/asperger.htm.	F 319		

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F 319	Continued From page 65 ***"Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website http://www.nimh.nih.gov/health/publications/schizophrenia-booklet-12-2015/index.shtml	F 319		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review it was determined that facility staff failed to maintain a safe environment on one of 4 units, 400's unit (secured unit). The facility staff failed to ensure that one of four facility janitor closets was secure. The janitor closet on the South East Secure Unit (400 unit) was observed to be unlocked. This closet contained chemicals. The findings include: During the general observation tour of the facility on 1/27/16 at 5:20 p.m. the janitor closet on the South East Secure Unit (400 unit) was observed to be unlocked. This closet had a key pad type lock.	F 323	**F323** **Corrective Action(s):** The 400 unit Janitor's closet door was closed and secured at time of discovery during the survey observation tour. A facility Incident and Accident form has been completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All Janitor's closets and storage closets may have been affected. A 100% review of all janitor's closets and storage closets will be conducted to identify potential accident hazard risks. All negative findings will be corrected at time of discovery and a facility Incident & Accident form will be completed for each incident. **Systemic Change(s):** All staff will be in serviced by the Administrator and/or Housekeeping Director regarding the prevention of resident accidents. The inservice will include the potential hazards of storing chemicals for room cleaning and disinfecting in unlocked closets the requirement to store external use items separate in a locked compartment or closet.	

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F 323	Continued From page 66 The following chemicals were observed in this closet: · High Performance Neutral Floor Cleaner · Alkaline Bathroom Cleaner & Disinfectant · Antibacterial All Purpose Cleaner · Glass Cleaner · Disinfectant Cleaner · Bio-Enzymatic Odor Eliminator Waterfall Mist This observation was confirmed with another state inspector who had observed a Resident wandering the hallways of the secured unit, trying door knobs. During an interview on 1/27/16 at 5:30 p.m. with ASM (Administrative Staff Member) # 1, the administrator, this observation was shared. ASM # 1 immediately secured the closet. At this time a request for the Safety Data Sheets (SDS) for all the unsecured chemicals and a facility policy for securing chemicals was made. During an interview on 1/27/16 at 5:35 p.m. with LPN (Licensed Practical Nurse) # 4, the charge nurse of the South East Secure Unit, the janitor closet was discussed. LPN # 4 stated that she did not know that it (the janitor closet) could be left unlocked. LPN # 4 further stated, "These people wander around down here." During an interview on 1/28/16 at 1:45 p.m. with OSM (Other Staff Member) # 7, a housekeeper, the securing of the janitor closets was discussed. OSM # 7 stated, "The closets are locked, there are dangerous chemical in there." An interview on 1/29/16 at 8:15 a.m. with OSM # 4, the Director of Environmental Services, the	F 323	**Monitoring:** The Maintenance Director and Environmental Director are responsible for compliance. The Maintenance Director and/or Environmental Director designee will perform daily rounds to ensure there are no potential accident hazards related to chemical storage areas or Storage closets. All negative findings will be corrected at time of discovery and a Facility Incident and Accident form completed for each incident. Results of the daily rounds will be reviewed weekly during the Risk Management Committee Meeting. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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F 323	Continued From page 67 unsecured janitor closet was discussed. OSM # 4 agreed that the closet should have been locked and further stated that it could no longer be opened without pressing in the code. As stated earlier a Resident on the South East Secure Unit was observed wandering around and trying door knobs. This Resident was identified as Resident # 17 in the survey sample. On 1/27/16 at 2:25 p.m. Resident # 17 observed walking up and down the hallways; attempting to open doors that were closed. The Resident tried four times to open an exit door to unit. Resident # 17 was admitted to the facility on 12/5/14 and readmitted on 1/20/15 with diagnoses that included, but were not limited to: diabetes, hypertension, hyperlipidemia, gastroesophageal reflux disease, glaucoma, and Alzheimer's disease. Resident # 17's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/27/15. Resident # 17 was coded as being severely impaired for daily decision making. In Section E Behavior under E0900 Wandering - Presence & Frequency this behavior was coded as "3" Behavior of this type occurred daily. Review of "Follow-Up Psychiatric Progress Note" dated 12/11/15 documented: "pt (patient) still rambles and wanders all up and down the halls." Review of the facility policy: "General Chemical Storage In (sic) the Facility" documented the following: Under "Policy Statement: All chemicals in the facility shall be identified with appropriate precautionary measures." Under "Policy	F 323		

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F 323	Continued From page 68 Interpretation and Implementation: 6. All chemicals used in all departments must (sic) stored in a secured area separate from non chemical (sic) items when not in use by staff." During an interview on 1/28/16 at 4:00 p.m. with ASM (Administrative Staff Member) # 1, the Administrator, and ASM # 3, the Regional Nurse Consultant, the unsecured janitor closet was shared. The SDS (safety data sheets) were reviewed and documented the following: · High Performance Neutral Floor Cleaner - Causes eye irritation. Harmful if inhaled. · Alkaline Bathroom Cleaner & Disinfectant - Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage. · Antibacterial All Purpose Cleaner -- Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage. · Glass Cleaner -- Causes eye irritation. · Disinfectant Cleaner -- Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage. · Bio-Enzymatic Odor Eliminator Waterfall Mist -- May cause an allergic skin reaction. Causes serious eye irritation.	F 323	**F 363** **Corrective Action(s):** All dietary staff has been inserviced on the proper procedure for serving, preparing, distributing food in a way that is flavorful, palatable, attractive, and in the correct portion size and amounts as indicated on the planned menus. An Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The CDM, and/or Registered Dietician will monitor food portions and food servings during the meal passes for 3 days to identify any negative findings. All negative findings will be corrected at time of discovery. A Risk Management Incident Report will be completed for each negative finding identified. **Systemic Change(s):** The facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will inservice the CDM and dietary staff on using the proper serving utensils and preparing/serving food according to the planned menu.	
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		

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F 363	Continued From page 69 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility documentation, the facility staff failed to ensure the planned Menu to meet the nutritional needs of residents, was properly prepared and followed. The ordered meat portions of three ounces were not consistently provided to the residents. The findings include: Review of the resident council meeting minutes from 11/17/15, 12/30/15 and 1/26/16 documented residents concern that they thought the food portions had gotten smaller. On 1/27/16 at 5:00 p.m. an observation of the dinner service tray line was made. The entree was pork lo mien. The dietary staff were observed to take a serving of noodles with tongs and then would pick pieces of pork out of the noodles and place on the serving. Dinner plates were observed with varying number of pieces of pork. At times there did not appear to be any pork on the noodles. A few small pieces of greenish/brown broccoli were noted in the noodles. At 6:05 p.m. OSM (other staff member) #3, the dietary manager, was asked what the meat serving size was, OSM #3 stated, "Two ounces." When asked how the meat portion was determined in the lo mien OSM #3 stated, "I can't guarantee (the meat serving portion) because it's mixed (in with the noodles)." An interview was conducted with OSM #3 on	F 363	**Monitoring:** The CDM is responsible for maintaining compliance. The CDM will perform 3 random meal preparation reviews weekly to monitor for compliance. The results of these reviews will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSTONE	900 S MAIN ST BLACKSTONE, VA 23824

(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 363	Continued From page 70 1/28/16 at 8:10 a.m. When asked who provided the required food portions OSM #3 stated, "The dietitian. I was wrong it (the meat portion) should have been three ounces not two ounces." An interview was conducted on 1/28/16 at 9:05 a.m. with OSM #11, the assistant dietary manager. When asked how the serving staff knew what portions were to be served OSM #11 stated, It's on the addition form (the extended menu). It shows you exact servings and exact portions on it." When asked how servers knew they were serving the correct amount of lo mien and pork, OSM #11 stated, We just realized it this morning, she (the server) did it wrong, she was supposed to get the three ounce utensil to get meat and veggies." She stated that the meat and vegetables were not supposed to be mixed in with the noodles and that it looked like there were too many noodles served. A review of the menu for week four day four listed pork lo mien with peppers serving amount to be eight ounces. On 1/28/16 at 5:30 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, were made aware of the findings.	F 363		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	**F 364** **Corrective Action(s):** All dietary staff has been inserviced on the proper procedure for serving, preparing, distributing food in a way that is flavorful, palatable, attractive, and at the proper temperature. The RD and CDM have reviewed the Federal and State guidelines for preparing, distributing and	

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F 364	Continued From page 71 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to prepare and serve food in a palatable and nutritive manner. Food served for dinner on 1/27/16 at 6:30 p.m. was not palatable and tasted as follows: pureed ravioli and broccoli had little taste and were sticky and pasty; steamed broccoli was a pale green and did not require chewing as it was so soft. The findings include: An anonymous complaint received alleged that the food was either overcooked or undercooked Resident #6 was admitted to the facility on 10/23/14 with diagnoses that included but were not limited to: anxiety disorder, muscle weakness and high blood pressure. Resident #6's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/22/15, coded the resident as being cognitively intact (scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS). On 1/27/16 at 4:10 p.m. an interview was conducted with Resident #6. When asked how the food at the facility tasted, Resident #6 stated, "Don't talk about that." When asked what she meant, Resident #6 stated the food was not cooked the way she preferred it cooked and the food was mostly overcooked. On 1/27/16 at 5:35 p.m. Resident #6 was observed feeding herself in	F 364	maintaining foods at the proper temperatures and to prepare and serve food in a palatable and nutritive manner. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The Administrator, CDM, and/or Registered Dietician will randomly monitor and sample test trays of all meals for the next 3 days prior to serving to identify any negative findings. All negative findings will be corrected at time of discovery. A Risk Management Incident Report will be completed for each negative finding identified. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will inservice the CDM and dietary staff on the proper sanitation, storage, cleaning and transportation of dietary products per established policy and procedure. The inservice will include preparing palatable and nutritive foods and maintaining hot and cold temperatures during meal tray set up and delivery.	

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F 364	Continued From page 72 her room. Observation of the resident's meal tray revealed the broccoli was dark green and mushy; the egg roll was dark brown and crisp. Resident #6 ate two bites of her broccoli and stated she ate all of the broccoli she could. A group interview was held on 1/28/16 at 2:30 p.m. with five residents who were cognitively intact. When asked about the food served, residents stated, "It's not worth a damn, taste or temperature; broccoli is overcooked." The residents also stated that the there is not enough variety, the food was not cooked well. The green beans were undercooked, the rolls were gummy, the cornbread was mushy and the seafood was of such low quality they should take it off the menu." Review of the resident council meeting minutes from 11/17/15, 12/30/15 and 1/26/16 documented resident concerns that they thought the food portions had gotten smaller, the food was unhealthy such as too much gravy and grease. The residents did not like the eggs, the yeast rolls were undercooked and they would like to have a salad at least one time a day. On 1/27/16 at 5:00 p.m. the beginning of the dinner tray line service was observed by two surveyors. A test tray of food served was requested as the last food tray was being completed. Three surveyors followed the last food cart and observed as the residents were being served from the cart. At 6:30 p.m. OSM #3, the dietary manager, assisted the three surveyors in tasting all the items on the tray. The pureed ravioli had a slight tomato taste and a pasty, sticky consistency. When asked what the ravioli tasted like OSM #3 stated, "It tastes like tomatoey thickener." When asked what the pureed broccoli	F 364	**Monitoring:** The CDM is responsible for maintaining compliance. The Administrator and/or CDM will perform random test tray samplings weekly to monitor for compliance. The results of these reviews will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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F 364	Continued From page 73 tasted like OSM #3 stated, "I can taste the thickener." The surveyors tasted the steamed broccoli. The broccoli was a very pale green and in small bits. The broccoli did not require chewing. When asked about the texture of the broccoli OSM #3 stated, "The residents like the veggies well cooked." When asked if the food was tasted by the dietary manager OSM #3 stated, "I eat the food here everyday but I'm usually not here for dinner." When asked if the residents voiced any concerns about the food, OSM #3 stated, "When I first got here, yes. We've made improvements over time." An interview was conducted on 1/28/16 at 9:05 a.m. with OSM #11, the assistant dietary manager. When asked if she routinely tasted the resident's food, OSM #11 stated that they did not routinely taste the pureed foods. OSM #11 stated that she had tasted the food from the previous evening and that, "The ravioli tasted like ravioli but had an after taste. I didn't like the (pureed) broccoli at all. We need to season it."	F 364		
F 371 SS=F	Complaint Deficiency 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F 371** **Corrective Action(s):** The CDM has reviewed the Federal and State guidelines for preparing, storing, distributing food under sanitary conditions, as well as the policy and procedure for establishing a proper cleaning schedule, the proper storage of clean dishware. All kitchen dishware and equipment identified as dirty on the initial kitchen tour were immediately re-washed or cleaned. The Ice Machine has been completely emptied and sanitized prior to	

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F 371	Continued From page 74 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to prepare and serve food in a sanitary manner. Several pans were observed wet nesting, ovens, can opener blade, ice machine and a cart for clean trays were all observed to be dirty. The findings include: On 1/27/16 at approximately 11:25 a.m. the inspection of the kitchen was conducted. The following concerns were identified: 6 large cookie-sheet style pans were wet nesting. 2 half-size cookie-sheet style pans were wet nesting. 2 large metal deep-dish steam table pans were wet nesting. A metal multi-level cart/rack containing a supply of large cookie-sheet style pans on each level was dirty with loose debris in the tracks that the pans rested on, as well as dried stuck-on food debris on all aspects of the cart/rack. In addition, at the bottom level of this cart/rack was 3 of these cookie-sheet style pans that were dirty and had not been washed. 2 large metal mixing bowls and one large metal colander were stacked inverted and ready for use. Around the lip of these 3 bowls was caked-on sticky brown substance.	F 371	re-use. A facility Incident & Accident report has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The Administrator, CDM, and/or Registered Dietician will monitor the kitchen preparation area and the cleaning of these areas during and after meals 3 times a week to identify any negative findings. All negative findings will be corrected at time of discovery. A facility Incident & Accident report will be completed for each negative finding identified. All negative findings will result in appropriate disciplinary action. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will inservice the CDM and dietary staff on the proper sanitation, storage, cleaning and transportation of dietary products per established policy and procedure. The inservice will include all aspects of infection & sanitation control measures, appropriate cleaning and storing of dietary equipment.	

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F 371	Continued From page 75 The can opener blade was dirty with loose and stuck-on debris. The 2 convection ovens and a third oven were dirty with black and brown dried-on debris inside them. Upon opening the lid to the ice machine, dried and loose debris were observed along the lower rim of the machine opening. A tan color buildup of debris was observed around the hinge of the ice machine lid and could potentially fall off into the ice. Inside the machine on the face of the ice maker, a small amount of black buildup was observed. On 1/27/16 at 11:50 a.m., each of these identified items was discussed with OSM #1 (Other Staff Member) the dietary manager. He stated that each of these items should be clean and ready for use. When asked about a cleaning schedule, he was not able to show but a few scattered days of a daily cleaning schedule (11/16/15, 11/17/15, 11/18/15, 11/19/15, 11/20/15, 11/21/15, 11/22/15, 11/23/15, 11/24/15, 12/29/15, 12/30/15, 1/13/16, and 1/20/16 - for a total of 13 days over a 3 month period) and had not been utilizing any weekly or deep-cleaning schedule. A review of the policy for "Ice" documented, "Ice will be maintained and served to residents in a sanitary manner." A review of the policy for "Dishwashing" documented, "2. Dishes will be stacked and rinsed free of large loose food particles. Dirt shall be loosened by scrubbing the surface of the dishware with a brush or an abrasive pad and	F 371	**Monitoring:** The CDM is responsible for maintaining compliance. The dietary audit tool for monitoring food preparation and storage, as well as, sanitation/infection control will be completed 3 times a week by the Administrator and/or Food service manager weekly for monitoring and maintaining compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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F 371	Continued From page 76 rinsing....7. allow clean dishes to air dry completely before storing...." On 1/28/16 at the end of day meeting at approximately 5:30 p.m., the ASM #1(Administrative/Corporate Staff, the Administrator), ASM #2 (the Director of Nursing), RN #1 (Registered Nurse, the Assistant Director of Nursing), and ASM #3 (the regional nurse consultant) were made aware of the findings. No further information was provided by the end of the survey. According to the Federal Food and Drug regulations: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. · (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. · (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. · (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 4-901.11 Equipment and Utensils, Air-Drying Required. Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils.	F 371		

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F 372 F 372 SS=C	Continued From page 77 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to maintain the dumpster area in a clean and sanitary manner to prevent pests. The findings include: On 1/28/16 at approximately 1:00 p.m. the inspection of the dumpster area was conducted with OSM #4 (Other Staff Member, Environmental Services Director). There were 4 dumpsters noted. He pointed out that 2 were used for general trash and 2 were used for dietary. One of the dietary dumpsters was observed to have a white liquid dripping from it. There was a trail of this liquid mixed with environmental liquid (water and/or melted snow) trailing away from the dumpster towards the loading dock area. When asked how often this area was cleaned, OSM #4 stated everyday by different departments (environmental services, maintenance, and dietary). On 1/28/16 at approximately 2:10 p.m., OSM #1 (dietary manger) was made aware of this finding regarding the dietary dumpster. He stated that he would look into the dumpster concern to determine if the facility could get a new one. He stated nothing should be leaking from it.	F 372 F 372	F-372 **Corrective Action(s):** The area around the dumpsters was cleaned of the trash on the ground and it was properly disposed of inside the dumpsters. The ground around the dumpsters was power sprayed to eliminate associated residuals. **Identification of Corrective Deficient Practice(s) & Corrective Action(s):** All other garbage disposal areas have the potential to be affected. The Maintenance Director and Environmental Services Director will inspect all garbage storage areas to identify risk. Any/All negative findings will be corrected at time of discovery. **Systemic Change(s):** The facility policy & procedure for the storage and disposal of refuse was reviewed and no changes are warranted at this time. The Maintenance Director and/or Environmental Services director will provide in-services to all staff on the proper techniques for the collection, storage, and disposal of refuse. The inservice training will include disposing of all refuse inside supplied dumpsters and keeping lids closed at all times.	

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F 372	Continued From page 78 A review of the policy for "Disposal of Garbage and Refuse" documented, "1. Garbage and refuse containers should be free from cracks or leaks and covered when not in use...." On 1/28/16 at the end of day meeting at approximately 5:30 p.m., the ASM #1(Administrative/Corporate Staff, the Administrator), ASM #2 (the Director of Nursing), RN #1 (Registered Nurse, the Assistant Director of Nursing), and ASM #3 (the regional nurse consultant) were made aware of the findings. No further information was provided by the end of the survey.	F 372	**Monitoring:** The Environmental Services Director is responsible for maintaining compliance. The Maintenance Director and/or Environmental Services Director will complete rounds of dumpster areas daily to monitor and maintain compliance. Any refuse on the ground surrounding the dumpsters will be corrected immediately. The results of these rounds will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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.	F 431	**F431** **Corrective Action(s):** LPN #7 received disciplinary action for leaving medications unattended on the medication cart and has been inserviced by the regional nurse consultant on the Proper Medication Administration Policy to include storing all medications in a locked medication cart when it is not in line of sight or in control of the Licensed Nursing staff. A facility incident & accident report was completed for this incident.	

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F 431	Continued From page 79 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 documentation review it was determined that facility staff failed to secure medications on one of 4 units; the 100 unit medication cart. The facility staff failed to secure a bottle of Novolog* and Novolin N** in the medication cart during medication administration pass on the 100 unit. The medications were left on top of the medication cart unsecured while the cart was out of LPN (licensed practical nurse) #7's line of sight. The findings include: On 1/27/16 at 4:15 p.m. the medication administration observation was conducted. At 4:36 p.m. on the 100 unit, LPN (licensed practical nurse) #7 prepared medications for Resident #21. Resident #21 was admitted to the facility on 3/12/15 with diagnoses that included but were not limited to stroke, high blood pressure,	F 431	**Identification of Deficient Practices & Corrective Action(s):** All unit Medication Carts used to store and dispense medications and narcotics during medication passes may have been potentially affected. The DON and/or designee will conduct a 100% review of all licensed nurses during medication passes to identify any medication carts that are left unlocked or unattended during medication passes. Any/all negative findings will be corrected at time of discovery. A facility Incident and Accident form will be completed for each incident identified. **Systemic Change(s):** Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON and/or regional nurse consultant on the facility policy and procedure for storing medications and biological to include not leaving medications on the medication carts unattended. The Pharmacy consultant will check each medication carts and medication room for improper storage of medications monthly during scheduled visits. The DON and/or Unit managers, will monitor each medication cart daily for proper storage of medications and biological to include leaving the medication cart unlocked and unattended during medication pass.	

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F 431	Continued From page 80 hyperlipidemia, atherosclerosis (hardening of the arteries), impaired right renal tubular function and abnormality of gait and mobility. Resident #21's most recent comprehensive MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 3/12/15. Resident #21 was coded as being moderately impaired in the ability to make daily life decisions scoring 8 out of 15 on the BIMS (Brief Interview for Mental Status) exam. LPN #7 prepared the following medications for Resident #21: Flonase*** 50 mcg (micrograms) 0.005%: 1 spray into both nares daily; Oxybutynin**** 5mg (milligrams): 1 tab (tablet) TID (three times a day); Sliding Scale Novolog (Insulin): 2 units for a blood sugar level of 173; and Novolin N (Insulin): 12 units (scheduled) before dinner. At 4:36 p.m. LPN #7 prepared the flonase and oxybutynin tablet. She then took out the glucometer (device used to test blood sugar) and prepared a test strip. She knocked on the Resident's door and explained the procedure. She administered the flonase to Resident #21; one spray into each nares. She then gave him the oxybutynin tablet. After Resident #21 swallowed the tablet she tested his blood sugar. He had a reading of 173. She then disposed of the lancet, took off her gloves and sanitized her hands. She took out Novolog (insulin) and drew up 2 units per sliding scale. In a separate insulin needle, she drew up 12 units of Novolin N. She then entered the resident's room at 4:47 p.m., while leaving the two bottles of insulin on the medication cart. She shut Resident #21's door while she was in the resident's room. The medication cart was not in her view. She was	F 431	**Monitoring:** The DON is responsible for maintaining compliance. The DON or Unit Manager will perform 2 random weekly audits of the medication carts to monitor for compliance. All discrepancies found in these audits with Medication carts unlocked or with medications unsupervised from a licensed nurse will be corrected at the time of discovery and appropriate disciplinary action taken as warranted. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSTONE	900 S MAIN ST BLACKSTONE, VA 23824

(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 431	Continued From page 81 back at the medication cart at 4:50 p.m. During this observation, Resident #18 was sitting in a wheelchair right behind the medication cart. Resident #18 was sitting near the cart when LPN #7 left the medication unsecured. Resident #18 was admitted to the facility on 4/17/15 with diagnoses that include but were not limited to schizophrenia, bipolar disorder, major depressive disorder, anxiety disorder, high blood pressure, chronic kidney disorder, chronic obstructive pulmonary disease, and dysphagia (difficulty swallowing). Resident #18 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 (zero) out of 15 on the BIMS (Brief Interview for Mental status) Exam on a 4/24/15 admission MDS. Resident #18 was coded as having delusions and verbal behaviors. On 1/27/16 at 4:52 p.m., an interview was conducted with LPN #7. When asked if medications were allowed to be left on the cart unattended she stated, "No. Medications are not allowed to be left on the cart. I normally put it away. When asked why medications cannot be left unattended on top of the medication cart she stated, "Because another resident could come around and take the bottle." On 1/28/16 at 5:26 p.m., administration was made aware of the above findings. No further information was provided during the time of survey. Facility policy titled, "Storage of Medications" documents in part, the following: "...7. Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts and	F 431		

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F 431	Continued From page 82 boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. *Novolog-fast acting insulin used to manage high blood sugar in patients with Type 1 or 2 diabetes mellitus. This information was obtained from Davis's Drug Guide for Nurses 11th edition, p. 670. **Novolin N-intermediate acting insulin used to manage high blood sugar in patients with Type 1 or Type 2 diabetes mellitus. This information was obtained from Davis's Drug Guide for Nurses 11th edition, p. 673. ***Flonase-corticosteroid that decreases the symptoms of allergic or nonallergic rhinits. This information was obtained from Davis's Drug Guide for Nurses 11th edition, p.347. ****Oxybutynin-increases bladder capacity. Delays desire to void. This information was obtained from Davis's Drug Guide for Nurses 11th edition, p.924.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	**F 441** **Corrective Action(s):** Resident #11's torn fall mat has been replaced. A facility Incident & Accident form was completed for this incident.	

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F 441	Continued From page 83 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement infection control practices for one of 26 residents in the survey sample, Resident #11. The facility staff failed to maintain Resident #11's fall mat free from a torn area, exposing foam that was unable to be sanitized. The findings include:	F 441	**Identification of Deficient Practice(s) and Corrective Action(s):** All other resident's utilizing fall mats while bed may have potentially been affected. A complete documented environmental walkthrough of the facility will be conducted by the administrator, maintenance director, and environmental services director to identify residents at risk. All resident fall mats identified that are torn will be removed from service and replaced immediately at the time of discovery. **Systemic Change(s):** The facility Infection Control policy for cleaning and storing resident equipment has been reviewed and no changes are warranted at this time. The nursing staff and environmental staff will be inserviced by the DON and/or ADON on the facility's infection control policy and procedure. To include the protocol to be used for cleaning, storing and inspecting fall mats for cracks, tears or being unserviceable.	

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F 441	Continued From page 84 Resident #11 was admitted to the facility on 6/15/15 with diagnoses that included but were not limited to: muscle weakness, *cardiac arrhythmia (a problem with the rate or rhythm of your heartbeat) and low blood pressure. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/24/15, coded the resident's cognitive skills for daily decision making as being severely impaired. Resident #11 was coded as being totally dependent of one staff with locomotion on the unit. Resident #11's comprehensive care plan with a problem onset date of 6/18/15 documented, "Fall mat at bedside, check placement q (every) shift when resident in bed..." On 1/27/16 at 2:40 p.m. and 1/28/16 at 8:00 a.m., Resident #11 was observed in a wheel chair in the dining room. Observation of Resident #11's room revealed the resident's fall mat was folded and sitting on the floor against the foot of the resident's bed. A torn area approximately four inches long by one half inch wide was observed on the edge of the mat. Foam was exposed sticking out of the plastic covering. On 1/28/16 at 1:32 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked how staff ensures residents' fall mats are maintained in good repair without torn areas. CNA #1 stated, "If we see it torn we put in a work request to have it changed or go to the supervisor and let the charge nurse know." When asked if she had noticed any torn areas on Resident #11's fall mat, CNA #1 stated she had not. CNA #1 stated she didn't use the	F 441	**Monitoring:** The DON and Environmental Director are responsible for maintaining compliance. The DON or Environmental Director and/or designee will complete daily environmental rounds to monitor fall mats for compliance. The Environmental Staff will also monitor for proper storage during daily room cleaning. Any negative findings will be corrected at time of discover and reported to the DON and/or Environmental Director. Aggregate findings of the audits will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date:** 3-14-16	

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F 441	Continued From page 85 resident's fall mat and it was utilized by night shift. When asked if Resident #11 ever took naps during the day shift, CNA #1 stated the resident only naps during the day once in a while. At this time, CNA #1 was taken to Resident #11's room and shown the fall mat. CNA #1 stated she would report the torn fall mat and removed the mat from the room. On 1/28/16 at 4:25 p.m., an interview was conducted with CNA #2. CNA #2 was asked who was responsible for ensuring fall mats were kept clean and free from torn areas. CNA #2 stated she didn't think anyone did that and she had never seen anyone do that. When asked how to keep a torn fall mat clean and free of bacteria, CNA #2 stated, "I don't think you can. I would get a new one." On 1/28/16 at 5:52 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility policy titled, "Cleaning and Disinfection of Resident-Care Items and Equipment" documented in part, "Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard..." The policy did not specifically document information regarding fall mats. No further information was presented prior to exit.	F 441		

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F 441	Continued From page 86 *This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/arrhythmia.html	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to obtain physician ordered laboratory tests 1 of 26 residents in the survey sample; Resident #3 The facility staff failed to obtain Resident # 3's physician ordered HgA1c* (also called HbA1c, HgbA1c, or Hemoglobin A1c) test and Lipid** tests for January 2016. *HbA1c is a test that measures the amount of glycated hemoglobin in your blood. It is used to measure your blood sugar control over several months. It can give a good estimate of how well you have managed your diabetes over the last 2 or 3 months. Website accessed: http://www.nlm.nih.gov/medlineplus/ency/article/003640.htm **Lipid panel is a group of tests that are often ordered together to determine risk of coronary heart disease. They are tests that have been shown to be good indicators of whether someone is likely to have a heart attack or stroke caused	F 502	**F502** **Corrective Action(s):** Resident #3's attending physician has been notified that the facility failed to obtain a HgbA1c and an Lipid Panel ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who had physician ordered lab tests may have potentially been affected. A 100% audit of all resident's lab orders will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. The attending physicians will be notified of the missing labs, labs not obtained timely and labs obtained without a physician order. A facility Incident & Accident Form will be completed. **Systemic Changes:** The facility policy and procedure has been reviewed and no changes are warranted at this time. The laboratory tracking system has been reviewed and implemented to track and validate that required lab work has been completed per physician order and policy and procedure. The DON and/or Regional Nurse Consultant will inservice all licensed staff on physician ordered laboratory-testing, protocols, & tracking system used.	

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F 502	Continued From page 87 by blockage of blood vessels or hardening of the arteries (atherosclerosis). Website accessed http://labtestsonline.org/understanding/analytes/lipid/tab/glance The findings include: Resident #3 was admitted to the facility on 4/22/09 with the diagnoses of but not limited to Alzheimer's dementia, schizophrenia, anxiety, Hepatitis C, high blood pressure, emphysema, contractures, aphasia, and depression. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 11/13/15. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total care for all areas of ADL's (Activities of Daily Living) and was incontinent of bowel and bladder. A review of the clinical record revealed the most recently signed POS (Physician's Order Sheet) for November 2015 and signed by the physician on 11/14/15. This POS included an order dated 8/22/13 for "HGBA1C every 3 months." Results of this lab (laboratory) located in the record revealed the test was completed 4/1/15, 7/15/15, and 10/23/15, indicating the next month it was due was January 2016. As of survey this review on 1/28/16, the test had not been performed when other January 2016 labs were completed (on 1/21/16.) In addition, the POS revealed an order dated 8/22/13 for "Lipid every 6 months." Results of this lab located in the record revealed the test was completed 7/15/15, indicating the next month	F 502	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will complete the Facility Lab audit tool weekly to monitor for compliance. Any negative findings will be reported to the attending physician and disciplinary action will be taken as warranted. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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F 502	Continued From page 88 it was due was January 2016. As of survey this review on 1/28/16, the test had not been performed when other January 2016 labs were completed (on 1/21/16.) On 1/28/16 at 3:00 p.m., an interview was conducted with RN #4 (Registered Nurse) who was the nurse that tracked and ordered labs. She provided her "Routine Lab Schedule" sheet which she tracked labs to be performed for the month. The "Routine Lab Schedule" provided included Resident #3's name and had identified the HgA1C test was to be drawn in January 2016 along with other ordered labs. RN #4 then provided the lab slip dated 1/21/16, that was completed which identified to the lab staff which labs needed to be drawn. On this slip she had marked "TSH (thyroid stimulating hormone)"*** instead of "Hemoglobin A1c." She stated that it was a mistake and that she should have marked the HgA1c test instead of the TSH. Regarding the Lipid, her "Routine Lab Schedule" sheet had indicated the lab was due annually and therefore she had not intended to draw it again until July 2016. When asked about reconciling the ordered labs with her lab schedule form, she stated she had been at the facility only since October 2015 and in that time had not compared her schedule to the monthly POS for orders; that she only checked new phone orders that were written during the month. ***According to Mosby's Medical Dictionary, sixth edition, 2002. St. Louis, MO: Mosby, Inc. Page 1712, TSH (Thyroid stimulating hormone test) is a blood test used to measure TSH concentration, helping to differentiate primary from secondary hypothyroidism.	F 502		

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F 502	Continued From page 89 A review of the facility policy, "Lab and Diagnostic Test Results" documented: 1. The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility...." A review of the care plan for Resident #3 failed to reveal any interventions specifically identifying the obtaining and monitoring of labs as ordered. On 1/28/16 at the end of day meeting at approximately 5:30 p.m., the ASM #1(Administrative/Corporate Staff, the Administrator), ASM #2 (the Director of Nursing), RN #1 (Registered Nurse, the Assistant Director of Nursing), and ASM #3 (the regional nurse consultant) were made aware of the findings. No further information was provided by the end of the survey. According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007. Page 165, Laboratory tests are always interpreted in relation to the client's underlying health problems and treatment modalities. These results can also identify actual or potential health problems....Sometimes, laboratory tests and diagnostic procedures are used to judge the effectiveness of nursing interventions or medical treatment." And on page 236, "As an instrument of continuous client care and as a legal document, the client record should contain all pertinent assessments, planning, interventions, and evaluations for that client."	F 502		
F 504	483.75(j)(2)(i) LAB SVCS ONLY WHEN	F 504		

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F 504 SS=D	Continued From page 90 ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff performed a laboratory test without a physician's order for 1 of 26 residents in the survey sample; Resident #3. The facility staff performed a TSH (thyroid stimulating hormone)* laboratory (lab) test for Resident #3 without a physician's order. *According to Mosby's Medical Dictionary, sixth edition, 2002. St. Louis, MO: Mosby, Inc. Page 1712, TSH (Thyroid stimulating hormone test) is a blood test used to measure TSH concentration, helping to differentiate primary from secondary hypothyroidism. The findings include: Resident #3 was admitted to the facility on 4/22/09 with the diagnoses of but not limited to Alzheimer's dementia, schizophrenia, anxiety, Hepatitis C, high blood pressure, emphysema, contractures, aphasia, and depression. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 11/13/15. The resident was coded as severely cognitively impaired in ability to	F 504	**F504** **Corrective Action(s):** Resident #3's attending physician has been notified that the facility obtained a TSH lab tests without a physician order. A facility Incident & Accident form has been completed for laboratory test. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of resident clinical records will be completed to identify residents who may have had laboratory tests completed without a physician order. All negative findings will be corrected at the time of discovery and the attending physician will be notified. A Facility Incident & Accident form will be completed for each incident. **Systemic Changes:** The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced on the policy and procedure for obtaining resident laboratory tests, which includes obtaining a physician order prior to obtaining the lab test.	

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F 504	Continued From page 91 make daily life decisions. The resident required total care for all areas of ADL's (Activities of Daily Living) and was incontinent of bowel and bladder. A review of the clinical record revealed lab results dated 1/21/16 for a TSH level. No physician's order could be located for this lab. On 1/28/16 at 3:00 p.m., an interview was conducted with RN #4 (Registered Nurse) who was the nurse that tracked and ordered labs. She provided her "Routine Lab Schedule" sheet which she tracked labs to be performed for the month. The "Routine Lab Schedule" provided included Resident #3's name and had identified an HgA1C** test was to be drawn in January 2016 along with other ordered labs. RN #4 then provided the lab slip for Resident #3 dated 1/21/16, that was completed which identified to the lab staff which labs needed to be drawn. On this slip she had marked "TSH" instead of "Hemoglobin A1c." She stated that it was a mistake and that she should have marked the HgA1c test instead of the TSH. **HbA1c is a test that measures the amount of glycated hemoglobin in your blood. It is used to measure your blood sugar control over several months. It can give a good estimate of how well you have managed your diabetes over the last 2 or 3 months. Website accessed: http://www.nlm.nih.gov/medlineplus/ency/article/003640.htm A review of the facility policy, "Lab and Diagnostic Test Results" documented: 1. The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. 2. The staff will process test requisitions and	F 504	**Monitoring:** The DON is responsible for maintaining compliance. The DON, and/or designee will review all lab tests obtained weekly to ensure that all resident lab tests obtained had the appropriate physician order for the lab tests prior to obtaining. Any negative findings will be reported to the attending physician and the appropriate disciplinary action taken for staff involved. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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F 504	Continued From page 92 arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility...." A review of the care plan for Resident #3 failed to reveal any interventions specifically identifying the obtaining and monitoring of labs as ordered. On 1/28/16 at the end of day meeting at approximately 5:30 p.m., the ASM #1(Administrative/Corporate Staff, the Administrator), ASM #2 (the Director of Nursing), RN #1 (Registered Nurse, the Assistant Director of Nursing), and ASM #3 (the regional nurse consultant) were made aware of the findings. No further information was provided by the end of the survey. According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007. Page 165, Laboratory tests are always interpreted in relation to the client's underlying health problems and treatment modalities. These results can also identify actual or potential health problems....Sometimes, laboratory tests and diagnostic procedures are used to judge the effectiveness of nursing interventions or medical treatment." And on page 236, "As an instrument of continuous client care and as a legal document, the client record should contain all pertinent assessments, planning, interventions, and evaluations for that client."	F 504		
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	F 514	**F514** **Corrective Action(s):** Resident #7's attending physician has been notified that the facility staff failed to discontinue a dressing change after a pressure ulcer had healed and also documented that the treatment was given	

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F 514	Continued From page 93 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review it was determined that facility staff failed to maintain a complete and accurate clinical record for one of 26 residents in the survey sample; Resident #7. For Resident #7, facility staff failed to discontinue an order for a dressing change after the pressure ulcer was healed and documented that the treatment was given on the January 2016 TARS (treatment administration record). The findings include: Resident #7 was admitted to the facility on 8/4/15 and readmitted on 12/11/15 with diagnoses that included but not limited to high blood pressure, type two diabetes, stroke, dysphagia (difficulty swallowing), severe peripheral vascular disease and muscle weakness. Resident #7's most recent MDS (minimum data set) was a significant change assessment with an ARD of 12/18/15. The resident was coded as never understanding others and never being understood by others for communication. Resident #7 was coded as being	F 514	on the January treatment administration record in error. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of resident's medical records for the last 30 days will be conducted by the DON, ADON, Unit Manager, and or designee to identify residents at risk for inaccurate documentation. To include all MAR's & TAR's for inaccurate documentation. All negative findings will be clarified and/or correct as applicable at time of discovery and the attending physician notified. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include accurate documentation of medical information in the medical record, the Physician Orders, the MAR's and the TAR's according to the acceptable professional standards and practices.	

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F 514	Continued From page 94 severely impaired in the ability to make daily decisions. The resident was coded as being totally dependent on staff with transfers, dressing, eating, personal hygiene and bathing. Review of Resident #7's clinical record revealed a wound care specialist evaluation assessment dated 9/18/15 that documented the following: "Stage 3 pressure wound of the sacrum (Resolved on 9/18/15)." This wound was discovered on 8/28/15 and treatments were put into place. Further review of the clinical record revealed the September 2015 TAR (Treatment Administration Record) that documented the following: "Cleanse sacrum with DWC, apply Santyl* ointment and apply 4X4 allevyn** qd (every day)." This order was initiated on 9/10/15 and discontinued on 9/18/15 (the resolve date of the wound). Resident #7's clinical record revealed that she went to the hospital on 12/6/15 for pneumonia. Resident #7 arrived back to the facility on 12/11/15. Review of the physician order sheet dated 1/15/16 revealed an order that documented the following: "Cleanse sacral area with DWC (dermal wound cleanser*), apply skin prep periwound, apply santyl, and allevyn QD (everyday)." This order was discontinued on 1/28/16, the day of survey. Review of the December 2015 and January 2016 TARS (treatment administration record) revealed that Resident #7 had been receiving this treatment every day from 12/12/15 until 1/28/16 (the day the order was discontinued).	F 514	**Monitoring:** The DON is responsible for maintaining compliance. The DON, and/or designee will audit medical records, MAR's & TAR's weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3-14-16	

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F 514	Continued From page 95 On 1/28/15 at 4:45 p.m., wound care observation was conducted. Resident #7's skin on her sacrum was intact. No wound or breakdown was noted to this area. On 1/28/15 at approximately 4 p.m., an interview was conducted with LPN (licensed practical nurse) #6, one of the nurses who signed off on the January 2016 TAR for the sacral dressing. When asked if she knew what check marks mean on the TAR she stated, "What do you mean? I have never seen check marks." She then stated, "You mean when we give medications? It turns green on our e-tar screen that we did the treatment." When asked if she had worked 3-11 shift the majority of the month of January with Resident #7 she stated, "Yes." When asked about Resident #7's wounds, LPN #6 only mentioned the arterial wounds on Resident #7's left foot. When asked if Resident #7 had a sacral pressure ulcer she stated, "No. She used to have an area but it turned white." When asked if she administered the Santyl order LPN #6 stated, "Well I was actually wondering what was going on because she had no area but there was still an order." I was putting the dressing on until a few weeks ago when the day shift nurse told me that we were supposed to discontinue the order because the wound had healed." When asked if she could remember the date that she found out this information she stated, "No, I just know it was a few weeks ago." When LPN #6 was informed that her signature was documented the majority of the month of January as applying the treatment, she stated, "Sometimes I just check off treatments because she has a ton of wounds. I didn't realize the order was still there. I tend to do that. I have to be more careful. I should have just	F 514		

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F 514	Continued From page 96 discontinued the treatment. I thought the other nurse did it." When asked why LPN #6 did not discontinue the order when she first noticed the wound was healed she stated, "I thought the other nurse was going to do it." On 1/28/15 at 4:19 p.m., an interview was conducted with LPN (licensed practical nurse) #8. When asked what the checks mean on the December 2015 and January 2016 TARS she stated, "The checks indicate the treatment was given." When asked if it was ever ok to document a treatment was given when it really was not she stated, "No." On 1/28/15 at 4:21 p.m., an interview was conducted with RN (Registered Nurse) #6, the unit manager. When asked about the sacral wound order she stated that the order was somehow written when the Resident returned back from the facility on 12/11/15. When asked who is responsible for transcribing hospital discharge orders she stated," The unit managers, so me." When asked if this order was on the hospital discharge orders she stated, "No. The order just came over when it shouldn't have." When asked the process of transcribing orders she stated that she writes all the orders that are on the discharge list and reviews the orders to ensure medications are correct. When asked who is responsible for transcribing admission orders on weekends or night shifts she stated, "Our admissions only come during the day and week when the supervisors are here." When asked if Resident #7 had a sacral wound after 9/18/15 (date of resolve date) she stated, "No. I don't know what had happened; her bottom had not been bad." When asked what the "check marks" meant on the December 2015 and	F 514		

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F 514	Continued From page 97 January 2016 TARS she stated, "Checks mean the medication or treatment had been given." When asked if this treatment should have been provided if the wound was healed, she stated, "No." When asked if nursing should have discontinued the order when they realized the resident's sacral wound was healed she stated, "Yes, I definitely need other eyes to check these things." When asked if it was ok to document that this treatment was given when it was in fact not given she stated, "No, nursing should never check off a medication or treatment was given if it was not." On 1/28/15 at 4:30 p.m., administration was made aware of the above concerns. No further information was presented during the time of survey. Facility policy titled, Charting and Documentation, documents in part the following: "...3. All incidents, accidents, or changes in the resident's condition must be recorded." The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."	F 514		

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F 514	Continued From page 98 *Santyl ointment is an ointment that is applied directly to the wound and digests collagen in necrotic (dead) tissue. Use of Santyl should be terminated when debridement of necrotic tissue is complete and granulation is well established. This information was obtained from http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a7bf0341-49ff-4338-a339-679a3f3f953d. ** Allevyn- waterproof dressing that requires no additional tape or bandage. Suitable for exuding wounds (wounds with drainage). This information was obtained from http://www.ncbi.nlm.nih.gov/pubmed/8845677.	F 514		