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
	495217	A. BUILDING _____ B. WING _____	C 05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/19/15 through 5/21/15. Corrections are required for compliance with 42CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 155 certified bed facility was 132 at the time of the survey. The survey sample consisted of 27 current Resident Reviews (Residents #1 through #21 and #29 through #34) and 7 closed record reviews (Residents #22 through #28).	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	F164 It is the practice of this facility to provide privacy to residents while administering medication. I. The Director of Care Delivery (DCD) provided RN #5 education related to privacy during medication administration. Resident #29 will be provided privacy and dignity during transdermal medication	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tamara Dicus-Wilson | TITLE: Admin | (X6) DATE: 6-17-15

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 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. 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 privacy while administering medication for one of six residents during the medication administration observation, Resident #29. The facility staff administered a medication patch to Resident #29's right lower chest without providing privacy. The findings include: Resident #29 was admitted to the facility on 7/8/12 with diagnoses that included but were not limited to: osteoporosis (a bone disease), depressive disorder and aphasia (a speech disorder). Resident #29's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/11/15, coded the resident's cognitive skills for daily decision making as modified independence-some difficulty in new situations only. Section B coded Resident #29's speech clarity as no speech- absence of spoken words. Observation of RN (registered nurse) #5 applying a medication patch to Resident #29's right lower chest was conducted in the resident's room on	F 164	administration. II. Residents residing in the facility and receiving transdermal medications have the potential to be affected by this alleged deficient practice. III. Education was provided to staff by the Administrator related to providing privacy and dignity during medication administration and other times. Members of the Interdisciplinary Team (IDT) will conduct random visual audits during transdermal medication administration times to ensure the privacy can dignity of the residents is protected. The audits will be conducted 3 times a week for 4 weeks and once weekly for the following 60 days to ensure compliance. IV. Results of the audits will be presented to the QAPI committee for review and action	

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F 164	Continued From page 2 5/20/15 at 8:10 a.m. Resident #29 was lying in bed. The bed was located in the first half of the room as soon as you enter the door. The privacy curtain and door was open. While applying the patch, RN #5 pulled the collar of Resident #29's shirt down, exposing the right lower portion of the resident's chest. At this time, this surveyor observed another employee walking past the room. On 5/20/15 at 8:55 a.m., an interview was attempted with Resident #29 regarding how she felt about her right lower chest being exposed without privacy being provided. The resident was unable to verbalize how she felt. On 5/20/15 at 1:53 p.m., an interview was conducted with RN #5. RN #5 was asked what should be done in regards to privacy while applying a medication patch to a resident's chest. RN #5 stated, "Close the door." RN #5 stated she usually does close the door. RN #5 confirmed Resident #29 was unable to talk. On 5/20/15 at 6:15 p.m., the administrator and director of nursing were made aware of the above findings. On 5/21/15 at 7:55 a.m., an interview was conducted with RN #1. When asked what type of privacy should be provided to a resident while administering a medication patch, RN #1 stated, "The patient should be in the room. Make sure the door is closed and the curtain is pulled." The facility policy titled, "MEDICATION ADMINISTRATION: TRANSDERMAL DRUGS" documented in part, "PURPOSE: To administer medication for systemic or local effect by way of	F 164	as appropriate. The QAPI committee will determine the need for further audits and or action plans. V 7/6/15	

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F 164	Continued From page 3 applying to skin. PROCEDURE: 5. Introduce self, explain procedure and provide privacy..." No further information was provided prior to exit.	F 164		
F 226 SS=D	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, the facility staff failed to implement their policies and procedures for the pre-screening requirements for one of five employee record reviews, other staff member (OSM) #11. The facility staff failed to complete the criminal background check within 30 days of hire for other staff member #11, dietician. The findings include: Review of the employee records was completed on 5/21/15 at approximately 8:45 a.m. OSM #11's file documented her hire date as 2/11/15. There was no license verification in her record. The state police criminal record check was dated, 2/5/15. Documented on the form, "Transaction is being processed." A completed report was not located in the employee record. An interview was conducted with other staff	F 226	Past noncompliance: no plan of correction required.	

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F 226	Continued From page 4	F 226		

member (OSM) #6, the human resources staff member, on 5/21/15 at 9:45 a.m. When asked for the above information, OSM #6 stated, "I'm new and I did not have access to the state police system so HR (human resource) managers at other buildings were running these for me. I was not aware it said transaction pending. This employee, (OSM #11) was previous (name of former contract company) and we no longer have them and all of the employees had to go through the normal rehire process. We knew we had an issue and we initiated a plan of correction to deal with this." When asked who had the plan, OSM #6 stated the administrator had the plan. She further stated, "We just finished it and we are up to date and in compliance."

On 5/21/15 at 10:30 a.m. OSM #6 returned with a copy of the criminal background check for OSM #11 and it documented "No identifiable record."

An interview was conducted with the administrator (administrative staff member [ASM] #1) on 5/21/15 at 10:43 a.m. When made aware of the above concern, ASM #1 stated, "I just came in November and we realized we had a problem. I put in PIP (performance improvement plan) in place." A copy of the plan was presented. There was conflicting evidence on the plan. The date was documented as 1/20/14 and that was crossed off and a date of 5/18/15 was initialed by the administrator. The PIP addressed employees hired in November, December and January. The "Resolution date" was dated 5/15/15 and crossed off with a date of 5/17/15. The documented date of the PIP was after the resolution date. There were no new hires after 5/17/15. The plan is not sufficient evidence for past non-compliance.

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F 226	Continued From page 5 The facility policy, "Abuse, Neglect, Misappropriation of Patient Property Prevention" documented, "The center utilizes the employee screening process to identify information from: previous employers, with applicant permission; state licensing boards and registries, and above and criminal background checks." No further information was provided prior to exit.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 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 care in a dignified manner while administering medication for one of six residents during the medication administration observation, Resident #29. The facility staff exposed Resident #29's right lower chest while applying a medication patch in the resident's room without closing the door or utilizing the privacy curtain. The findings include: Resident #29 was admitted to the facility on 7/8/12 with diagnoses that included but were not limited to: osteoporosis (a bone disease),	F 241	F241 It is the practice of this facility to provide care in a dignified manner while administering medication. I. The DCD provided education to RN #5 related to providing care in a dignified manner. Resident #29 will be provided privacy and dignity during transdermal medication administration. II. Resident receiving transdermal medications have the potential to be affected by this alleged deficient practice.	

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F 241	Continued From page 6 depressive disorder and aphasia (a speech disorder). Resident #29's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/11/15, coded the resident's cognitive skills for daily decision making as modified independence-some difficulty in new situations only. Section B coded Resident #29's speech clarity as no speech- absence of spoken words. Observation of RN (registered nurse) #5 applying a medication patch to Resident #29's right lower chest was conducted in the resident's room on 5/20/15 at 8:10 a.m. Resident #29 was lying in bed. The bed was located in the first half of the room as soon as you enter the door. The privacy curtain and door was open. While applying the patch, RN #5 pulled the collar of Resident #29's shirt down, exposing the right lower portion of the resident's chest. At this time, this surveyor observed another employee walking past the room. On 5/20/15 at 8:55 a.m., an interview was attempted with Resident #29 regarding how she felt about her right lower chest being exposed without privacy being provided. The resident was unable to verbalize how she felt. On 5/20/15 at 1:53 p.m., an interview was conducted with RN #5. RN #5 was asked what should be done in regards to privacy while applying a medication patch to a resident's chest. RN #5 stated, "Close the door." RN #5 stated she usually does close the door but this was her first time with a state inspector. RN #5 confirmed Resident #29 was unable to talk. On 5/20/15 at 6:15 p.m., the administrator and	F 241	III. Education was provided to staff by the Administrator related to providing privacy and dignity during medication administration and other times. IV. Members of the IDT will conduct random visual audits during transdermal medication administration times to ensure the privacy and dignity of the resident is protected. The audits will be conducted 3 times a week for 4 weeks and once weekly for the following 60 days to ensure compliance. IV. Results of the audits will be presented to the QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits and or action plans. V.	

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F 241	Continued From page 7 director of nursing were made aware of the above findings. On 5/21/15 at 7:55 a.m., an interview was conducted with RN #1. When asked what type of privacy should be provided to a resident while administering a medication patch, RN #1 stated, "The patient should be in the room. Make sure the door is closed and the curtain is pulled." The facility policy titled, "MEDICATION ADMINISTRATION: TRANSDERMAL DRUGS" documented in part, "PURPOSE: To administer medication for systemic or local effect by way of applying to skin. PROCEDURE: 5. Introduce self, explain procedure and provide privacy..." No further information was provided prior to exit.	F 241	7/6/15	
F 272 SS=D	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;	F 272	F272 It is the practice of this facility to document the date and source of clinical record information utilized to complete the Care Area Assessment (CAA) worksheet of the MDS assessment. I. A vision assessment was completed for resident #7 and a care place was developed to reflect the results of the assessment. II. Residents who have care area	

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F 272	Continued From page 8 Continence; 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, facility document review, and clinical record review, the facility staff failed to document date and location of clinical record information utilized to complete the CAA (Care Area Assessment) worksheet of the MDS (minimum data set) assessment for 1 of 34 residents in the survey sample; Resident #7. The facility staff failed to document date and location of clinical record information utilized to complete the CAA (Care Area Assessment) worksheet for vision on the annual MDS (minimum data set) with an ARD (assessment reference date) of 3/23/15, for Resident #7. The findings include:	F 272	triggers upon completion of their MDS have the potential to be affected by this alleged deficient practice. An audit of the comprehensive MDS assessments completed over the past 30 days was performed to ensure accurate documentation of date and source of information for triggered care areas. Corrections were submitted as needed. III. Education was provided to the Interdisciplinary Team (IDT) responsible for the completion of the comprehensive MDS by the Case Mix Specialist to ensure knowledge of documenting the date and source of information used to complete the Care Area Assessment (CAA) of the MDS. The triggered CAA sheet from OBRA required MDSs completed in the next 30 days will be printed and reviewed by the IDT prior to locking the assessment for submission to ensure both the date and source of the information related to the CAA is documented. The triggered CAA sheet from 5 OBRA required MDSs per week completed	

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F 272	Continued From page 9 Resident #7 was admitted to the facility on 4/1/08 with the diagnoses of but not limited to seizures, dysphagia, dementia, and osteoporosis. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 3/23/15. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total assistance for transfers, dressing, hygiene, and bathing; extensive assistance for eating; and was incontinent of bowel and bladder. A review of the clinical record revealed the above identified MDS. Under Section V (the CAA Summary section), Vision was documented as being a triggered area (as evidenced by an "X" in the box for column "A - Care Area Triggered" and was to be care planned as documented by an "X" in the box for column "B - Care Planning Decision." Under the column for "Location and Date of CAA documentation" for vision, was documented "CAA WS dated 4/2/15." Further review of the CAA worksheet failed to reveal any clinical record documentation. The CAA worksheet referred to itself as the source of documentation. On 5/21/15 at 1:36 p.m., in an interview with RN #2 (Registered Nurse #2, the MDS coordinator) she stated that information to complete the CAA worksheets "should come from the clinical record." She stated she was not the nurse that completed this MDS (the nurse who completed the MDS assessment was no longer at the facility) and therefore could not provide any further information on why the MDS was not completed accurately. At 1:55 p.m., RN #2 stated	F 272	over the following 60 days will be printed and reviewed by the IDT prior to locking the assessment for submission to ensure both the date and source of the information related to the CAA is documented. IV. Results of the reviews will be reviewed by the Administrator and submitted to the QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits and or action plans V. 7/6/15	

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F 272	Continued From page 10 the RAI (Resident Assessment Instrument) manual was the guideline the facility uses in completing MDS's. On 5/21/15 at 1:55 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey. 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 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.	F 272		
F 278 SS=D	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	F 278	F278 It is the practice of this facility to complete assessments which accurately reflect the resident's status. I. MDSs for residents #2 and #7 will be completed accurately beginning with the next required MDS submission following the RAI	

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F 278	Continued From page 11 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on 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 three of 34 residents in the survey sample, Residents #2, #7 and #1. 1. The facility staff failed to complete a pain interview on Resident #2's annual MDS assessment with an ARD (assessment reference date) of 3/11/15. 2. The facility staff failed to accurately document Resident #7's vision status on the annual MDS with an ARD of 3/23/15. 3. The facility staff failed to code a pressure sore	F 278	schedule. The MDS for resident #1 was corrected and submitted on 5/20/15. Resident #1 has discharged from the facility. II. Residents residing in the facility and requiring the completion of the MDS have the potential to be affected by this alleged deficient practice. An audit of completed MDSs which were submitted over the past 14 days was conducted to ensure accuracy. Any errors identified requiring a corrected MDS were corrected and the MDS was resubmitted. III. Education was provided to the IDT responsible for the completion of the MDS by the Case Mix Specialist to ensure their knowledge of accurate completion of their assessments. OBRA required MDSs completed for the next 14 days will be printed and reviewed by the IDT prior to submission to ensure their accuracy. Corrections will be made as needed. Three OBRA required MDSs	

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for Resident #1 on the 5-Day Minimum Data Set, with an Assessment Reference Date of 3/16/15. Resident #1 was coded as having only one pressure. Resident #1 was admitted to the facility with 2 pressure sores.

The findings include:

1. Resident #2 was admitted to the facility on 10/14/12 and readmitted on 8/19/14 with diagnoses that included but were not limited to diabetes (a blood sugar disorder), glaucoma (an eye disease) and high cholesterol. Resident #2's most recent MDS, an annual assessment with an ARD of 3/11/15, coded the resident as being understood and as understanding verbal content. Section C coded Resident #2 as being cognitively intact.

Section J of Resident #2's annual MDS with an ARD of 3/11/15 documented, "J0200. Should Pain Assessment Interview be Conducted? 1. Yes. Continue to J0300, Pain Presence." Dashes were coded for all pain assessment interview questions including: J0300 (Pain Presence), J0400 (Pain Frequency), J0500 (Pain Effect on Function) and J0600 (Pain Intensity). The staff assessment for pain was completed.

The person responsible for completing Resident #2's annual MDS with an ARD of 3/11/15 was no longer employed at the facility. On 5/20/15 at 2:55 p.m., an interview was conducted with RN (registered nurse) #2, the current MDS coordinator. RN #2 stated Resident #2's pain assessment interview should have been done. RN #2 stated she guessed the former MDS coordinator attempted the interview after the five day look back window but she couldn't speak for

completed each week will be printed and reviewed by the IDT for accuracy prior to submission for the next 6 weeks.

IV.
Findings of the MDS review will be reviewed by the Administrator and presented to the facility's QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits or action plans.

V.
7/6/15

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her. RN #2 stated she refers to the CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) manual while completing MDS assessments.

On 5/20/15 at 6:15 p.m., the administrator and director of nursing were made aware of the above findings.

The CMS RAI manual documents the following:

"J0200: Should Pain Assessment Interview Be Conducted?
Item Rationale
Health-related Quality of Life
·Most residents who are capable of communicating can answer questions about how they feel.
·Obtaining information about pain directly from the resident, sometimes called 'hearing the resident's voice,' is more reliable and accurate than observation alone for identifying pain.
·If a resident cannot communicate (e.g., verbal, gesture, written), then staff observations for pain behavior (J0800 and J0850) will be used.
Planning for Care
·Interview allows the resident's voice to be reflected in the care plan.
·Information about pain that comes directly from the resident provides symptom-specific information for individualized care planning.
Steps for Assessment
1. Determine whether the resident is understood at least sometimes. Review Language item (A1100), to determine whether the resident needs or wants an interpreter.
·If an interpreter is needed or requested, every effort should be made to have an interpreter

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present for the MDS clinical interview.

Coding Instructions
Attempt to complete the interview if the resident is at least sometimes understood and an interpreter is present or not required.
·Code 0, no: if the resident is rarely/never understood or an interpreter is required but not available. Skip to Indicators of Pain or Possible Pain item (J0800).
·Code 1, yes: if the resident is at least sometimes understood and an interpreter is present or not required. Continue to Pain Presence item (J0300).
Coding Tips and Special Populations
·If it is not possible for an interpreter to be present during the look-back period, code J0200 = 0 to indicate interview not attempted and complete Staff Assessment of Pain item (J0800), instead of the Pain Interview items (J0300-J0600).

J0300-J0600: Pain Assessment Interview
Item Rationale
Health-related Quality of Life
·The effects of unrelieved pain impact the individual in terms of functional decline, complications of immobility, skin breakdown and infections.
·Pain significantly adversely affects a person's quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as an increase in behavior problems, particularly for cognitively-impaired residents.
·Some older adults limit their activities in order to avoid having pain. Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management.
Planning for Care
·Directly asking the resident about pain rather

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than relying on the resident to volunteer the information or relying on clinical observation significantly improves the detection of pain.
·Resident self-report is the most reliable means for assessing pain.
·Pain assessment provides a basis for evaluation, treatment need, and response to treatment.
·Assessing whether pain interferes with sleep or activities provides additional understanding of the functional impact of pain and potential care planning implications.
·Assessment of pain provides insight into the need to adjust the timing of pain interventions to better cover sleep or preferred activities.
·Pain assessment prompts discussion about factors that aggravate and alleviate pain.
·Similar pain stimuli can have varying impact on different individuals.
·Consistent use of a standardized pain intensity scale improves the validity and reliability of pain assessment. Using the same scale in different settings may improve continuity of care.
·Pain intensity scales allow providers to evaluate whether pain is responding to pain medication regimen(s) and/or non-pharmacological intervention(s).
Steps for Assessment: Basic Interview
Instructions for Pain Assessment Interview (J0300-J0600)
1. Interview any resident not screened out by the Should Pain Assessment Interview be Conducted? item (J0200).
2. The Pain Assessment Interview for residents consists of four items: the primary question Pain Presence item (J0300), and three follow-up questions Pain Frequency item (J0400); Pain Effect on Function item (J0500); and Pain Intensity item (J0600). If the resident is unable to answer the primary question on Pain Presence

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item J0300, skip to the Staff Assessment for Pain beginning with Indicators of Pain or Possible Pain item (J0800).
3. The look-back period on these items is 5 days. Because this item asks the resident to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5- day look-back period; preferably on the day before, or the day of the ARD. This should more accurately capture pain episodes that occur during the 5-day look-back period..."

No further information was presented prior to exit.

2. Resident #7 was admitted to the facility on 4/1/08 with the diagnoses of but not limited to seizures, dysphagia, dementia, and osteoporosis. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 3/23/15. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total assistance for transfers, dressing, hygiene, and bathing; extensive assistance for eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed the above identified MDS. Under Section V (the CAA Summary section), Vision was documented as being a triggered area (as evidenced by an "X" in the box for column "A - Care Area Triggered" and was to be care planned as documented by an "X" in the box for column "B - Care Planning Decision." (The resident was coded in Section B01000 "Vision" as "Highly Impaired" as evidenced by a "3" being documented in the box for Vision (0 - Adequate, 1 - Impaired, 2 - Moderately Impaired, 3 - Highly Impaired, 4 - Severely Impaired.)

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A review of the comprehensive care plan failed to reveal one for vision, or vision addressed in any other care plan present.

On 5/21/15 at 1:10 p.m., the Director of Nursing came to the surveyor and stated the MDS for vision was coded wrong, that the resident did not require a care plan for vision; that the resident cannot be assessed for vision, and that this was a change from previous MDS assessments. (A review of the previous MDS, a quarterly dated 12/23/14, also had the resident coded as having highly impaired vision).

On 5/21/15 at 1:55 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey.

3. Resident #1 was a 75 year old who was admitted to the facility on 3/9/15. Resident #1's diagnoses included Pressure Ulcer, Hypertension, Muscle Weakness, and Difficulty Walking.

The Minimum Data Set, which was a 5-Day Assessment, with an Assessment Reference Date of 3/16/15 coded Resident #1 as having a Brief Interview of Mental Status Score of 8, indicating severely impaired cognition. In addition, Resident #1 was coded as having only one pressure ulcer, and as requiring the extensive assistance of two persons for physical transfers.

On 5/19/15 a review was conducted of Resident #1's clinical record, revealing the following

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Admission Nursing Assessment that documented, "3/9/15. Non-blanchable area on right great toe, large non-blanchable on left heel." Resident #1 was admitted to the facility with 2 pressure sores.

Resident #1's Care Plan documented, "3/10/15. Non-blanchable redness to left heel evolved into an open area related to impaired mobility. Will develop no new areas of skin breakdown. Administer treatment per physician orders. Encourage and assist as needed to turn and reposition." "3/9/15 Non-blanchable on right great toe. Administer treatment per physician orders. At risk for alteration in skin integrity related to impaired mobility. Provide preventive skin care routinely and as needed."

The clinical record contained the following Nursing Progress note, "3/20/15. Non-blanchable area on right toe slightly improved since last evaluation."

Resident #1's Physician Orders read, "4/2/15. Santyl Ointment 250 Unit/Gm Apply to left heel topically every day shift for open wound. Cleanse left heel with normal saline, pat dry, apply skin prep to the surrounding tissue, apply Santyl Ointment to the would bed, then 4x4 gauze, Mepliex foam, wrap with gauze bandage."

On 5/20/15 an observation was conducted of Resident's wound care on his left heel. The wound care nurse (registered nurse {RN #4}) provided Resident #1 with wound care in accordance with the physicians order.

On 5/20/15 a review was conducted of facility documentation, revealing the Resident Assessment Instrument 3.0 Manual Section M:

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F 278	Continued From page 19 Skin Conditions. It read, "A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Coding instructions for M0300B. Enter the number of pressure ulcers that are currently present. Enter the number of Stage 2 pressure ulcers that were first noted at the time of admission/entry and for residents who are reentering the facility after a hospital stay." On 5/20/15 an interview was conducted with the MDS (Minimum Data Set) Coordinator (RN 1). When asked to review the Admission Nursing Assessment dated 3/9/15, she stated, "I see 2 non-blanchable pressure sores on this nurse's note. I guess we didn't read it properly or didn't see the note." On 5/20/15 at 3:30 P.M. the Administrator was notified of the findings. No further information was received.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	F279 It is the practice of this facility to develop, review and revise the resident's comprehensive plan of care. I. A pacemaker care plan was developed for resident #12 on 5/20/15. A vision care plan was developed for resident #7 on 5/20/15.	

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F 279	Continued From page 20 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to develop comprehensive care plans for two of 34 residents in the survey sample, Residents #12 and Resident #7 1. a. The facility staff failed to develop a care plan to address Resident #12's pacemaker. 1.b. The facility staff failed to develop a care plan to address incontinence for Resident #12 that was triggered on the CAA (Care Area Assessment) of the admission MDS (minimum data set) assessment, with an ARD (assessment reference date) of 5/4/15. 2. The facility staff failed to develop a care plan to address Resident #7's vision, which was triggered on the CAA summary on the annual MDS with an ARD of 3/23/15. The findings include: 1. a. Resident #12 was admitted to the facility on 4/27/15 with diagnoses that included but were not limited to: muscle weakness, low thyroid, anemia, dysphagia (difficulty swallowing*) high blood pressure, encephalopathy (brain disorder*) urinary retention, and Parkinson's disease (a	F 279	II. Residents with Care Area Assessments (CAA) which trigger on the MDS the need for a care plan have the potential to be affected by this alleged deficient practice. An audit of CAAs triggered from the OBRA required MDSs completed over the past 30 days was performed to ensure the residents' plan of care was updated, revised or developed to address the CAA. Corrections were made when appropriate. III. Education was provided to the IDT responsible for the devclopment of comprehensive care plans by the Case Mix Specialist. The triggered CAA sheet from OBRA required comprehensive MDSs completed for the next 30 days will be printed for verification by the IDT that triggered CAAs requiring care plan development or revision have been addressed. For the next 60 days, 5 OBRA required comprehensive MDSs CAA worksheets will be audited each week to ensure required care plan development and/or revision occurs.	

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F 279	Continued From page 21 slowly progressing neurological disorder). The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, coded the resident has having both short and long term memory difficulties and as severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living. The admission nursing note dated, 4/28/15 at 12:43 a.m. documented, "Pt (patient) has a pacemaker/defibrillator that requires weekly phone checks and monthly in office checks per daughter." Review of the comprehensive care plan dated, 4/28/15, documented, "Focus: Cardiac disease related to hypertension (high blood pressure), CAD (coronary artery disease)." The "Interventions/Tasks" documented, "Administer medication per physician orders. Notify physician if heart rate less than 50. Obtain vital signs as indicated; report changes to physician." An interview was conducted with RN (registered nurse) #2, the MDS nurse; on 5/20/15 at 9:56 a.m. RN#2 was asked if a resident has a pacemaker, should it be addressed on the care plan. RN #2 stated, "Yes, it should be but we (the MDS nurses) don't care plan that, the nurses do." An interview was conducted with RN #3 on 5/20/15 at 10:54 a.m. When asked if a resident has a pacemaker, should it be on the care plan, RN #3 stated, "Yes." When asked who completes the care plan for this, RN #3 stated, "The supervisor who does the admission, initiates	F 279	IV. Results of this verification will be reviewed by the Administrator and submitted to the QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits or actions plans. V. 7/6/15	

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the care plan. The unit manager reviews it in morning meeting and the nurses can adjust the care plan at any time based on the resident's condition."

An interview was conducted with the director of nursing (DON) on 5/20/15 at 11:36 a.m. When asked if a resident has a pacemaker, should the pacemaker be addressed in the care plan. The DON stated, "Yes, It should be there."

The facility policy, "Care Plans." documented, "The facility must develop a comprehensive care plan for each resident that includes: Measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

The administrative team was made aware of

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these findings on 5/20/15 at 6:12 p.m.
* All medical definitions are taken from Barron's Dictionary of Medical Terms for the Non Medical Reader, 5th edition; Rothenberg and Chapman.

1. b. The facility staff failed to develop a care plan to address incontinence for Resident #12 that was triggered on the CAA (Care Area Assessment) of the admission MDS (minimum data set) assessment, with an ARD (assessment reference date) of 5/4/15.

The admission MDS assessment, with an ARD of 5/4/15 was reviewed. In Section V - Care Area Assessment Summary, the resident was checked under column, "Care Area Triggered" for urinary incontinence and indwelling catheter. The column, "Care Planning Decisions" was also checked with an "X" indicating that the triggered area was to be care planned for this resident.

Review of the comprehensive care plan dated as initiated, 4/28/15 through 5/5/15, did not reveal a care plan to address the resident's incontinence.

An interview was conducted with RN (registered nurse) #2, the MDS nurse, on 5/20/15 at 9:56 a.m. When asked who develops the care plans for the triggered areas on the CAA summary, RN #2 stated, "The MDS coordinator that completes the assessment." The CAA summary for Resident #12's admission MDS with an ARD of 5/4/15 was reviewed with RN #2. The care plan was reviewed with RN #2. When asked where the care plan for the triggered area of incontinence and indwelling catheter was located, RN #2 stated, "I don't see it." When asked if it was triggered on the CAA summary should it be care planned, RN #2 stated, 'Yes, if it says we're going

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to care plan it then it should be care planned."

An interview was conducted with the director of nursing (DON) on 5/20/5 at 11:36 a.m. The DON was asked if an area is triggered on the CAA summary of a comprehensive assessment, should that area that was triggered be addressed on the care plan. The DON stated, "Of course it should be."

The facility policy presented, a statement from the RAI (Resident Assessment Instrument) manual documented, "The Care Area Triggers are specific response options for the MDS that are indicators of 20 particular care areas that affect nursing home residents. When a trigger is entered as the response on a resident's MDS, additional assessment and review of the care area are required to determine the status of the issue. The facility must develop a comprehensive care plan for each resident that includes: Measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being."

The RAI Manual October 2014:
Coding Instructions for V0200A, CAAs
Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based

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or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation

For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision's column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed. For each triggered care area, Indicate the date and location of the CAA documentation in the "Location and Date of CAA Documentation" column. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.

The administrative team was made aware of these findings on 5/20/15 at 6:12 p.m.

2. The facility staff failed to develop a care plan to address Resident #7's vision, which was triggered on the CAA summary on the annual MDS with an ARD of 3/23/15.

Resident #7 was admitted to the facility on 4/1/08 with the diagnoses of but not limited to seizures, dysphagia, dementia, and osteoporosis. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment

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Reference Date) of 3/23/15. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total assistance for transfers, dressing, hygiene, and bathing; extensive assistance for eating; and was coded as incontinent of bowel and bladder.

A review of the clinical record revealed the above identified MDS. Under Section V (the CAA Summary section), Vision was documented as being a triggered area (as evidenced by an "X" in the box for column "A - Care Area Triggered" and was to be care planned as documented by an "X" in the box for column "B - Care Planning Decision."

A review of the comprehensive care plan failed to reveal one for vision, or vision addressed in any other care plan present.

On 5/20/15 at 11:10 a.m., the concern was brought to the attention of RN #2 (Registered Nurse #2, MDS coordinator). She reviewed the care plan on the computer and stated, "You're correct, it isn't there." She further stated the nurse that coded this MDS was no longer in the facility, and therefore was not able to provide any further information as to why Vision was not care planned.

On 5/21/15 at 8:00 a.m., a care plan for vision was provided, with an initiation date of 3/26/10. However, all goals and interventions were dated 5/20/15 (the day RN #2 was notified of the missing care plan). At approximately 8:30 a.m., when asked about the care plan, she stated, "I made it yesterday." No information could be provided as to why the initiation date was from

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F 279	Continued From page 27 2010. On 5/21/15 at 1:10 p.m., the Director of Nursing stated the MDS for vision was coded wrong, that the resident did not require a care plan for vision. At 1:36 p.m., in an interview with RN #2, she stated, that although it may be coded wrong, if it is triggered and documented to be care planned, then it should be care planned. On 5/21/15 at 1:55 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey. The following is taken from Section V of the MDS-Version 3.0: "Section V: Care Area Assessment: V0200. CAAs and Care Planning 1. Check column A if 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 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."	F 279		
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:	F 281	F281 It is the practice of this facility to provide services which meet professional standards of quality. I. Resident #12 was assessed for self-administration of his nebulizer treatment. The order for as needed Trazadone was discontinued on	

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F 281	Continued From page 28 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice for one of 34 residents in the survey sample, Resident #12. 1.a. The facility staff failed to observe Resident #12 while administering a medication through a nebulizer machine. b. The facility staff failed to clarify an order for an as needed antidepressant, Trazadone for Resident #12. The findings include: 1.a. Resident #12 was admitted to the facility on 4/27/15 with diagnoses that included but were not limited to: muscle weakness, low thyroid, anemia, dysphagia (difficulty swallowing*) high blood pressure, encephalopathy (brain disorder*) urinary retention, and Parkinson's disease (a slowly progressing neurological disorder). The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, coded the resident as having both short and long term memory difficulties and severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living. On 5/19/15 at 1:08 p.m., during the initial tour, of Resident #12 was observed in his room in a wheelchair with a nebulizer mask on. There was no one observed in the room with the resident. There were no nurses in the area of the resident's room. Resident #12 was observed until 1:18 p.m.	F 281	5/20/15 for resident #12. II. Residents having nebulizer treatment orders prescribed which may or may not be administered independently and residents prescribed an as needed antidepressant have the potential to be affected by this alleged deficient practice. An audit was conducted of the Medication Administration Record (MAR) for current residents to identify residents with nebulizer treatment orders which may be administered independently. Residents were assessed for the independent administering of those treatments if appropriate. An audit was conducted of the MAR to address any antidepressants which are prescribed to be administered as needed. Request for changes to the physician order was made as appropriate. III. Licensed staff were educated on the completion of the Self Administration of Medication assessment for patients who may be	

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F 281	Continued From page 29 with no nursing staff member entering his room. At this time, 1:18 p.m. the resident removed the nebulizer mask and placed in on the table. Two surveyors observed the mask on the table and the medication had been completely administered. The physician order dated 4/29/15 documented, "Albuteral Sulfate Nebulization Solution** 1.25 MG/3ML (milligrams per 3 milliliters); one dose inhale orally via nebulizer every 4 hours for SOB (shortness of breath)." This medication was scheduled at 1:00 p.m. **Albuterol is used to prevent and treat wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways). Albuterol inhalation aerosol is also used to prevent breathing difficulties during exercise. Albuterol is in a class of medications called bronchodilators. It works by relaxing and opening air passages to the lungs to make breathing easier. The comprehensive care plan, dated 4/28/15, documented, "Focus: Has/at (has or is at) risk for respiratory impairment related to SOB/wheezing." The "Interventions" documented, "Administer medications/treatments per physician orders." Review of the clinical record and the comprehensive care plan did not reveal any documentation or assessment that the resident could self administer medications. An interview was conducted with LPN (licensed practical nurse) #2 on 5/20/15 at 5:38 p.m. LPN	F 281	able to self-administer nebulizer treatments. Licensed staff were educated on the appropriate diagnosis for antidepressant medications as well as the appropriate frequency of administration by the ADNS or her designee. New patients with orders for nebulizer treatments will be assessed to determine their ability to self-administer those treatments for the next 30 days. 5 random audits will be conducted each week for the following 60 days to ensure compliance to this plan. New physician orders will be audited by the IDT for patients for the next 30 days to ensure appropriate diagnosis and frequency for prescribed antidepressant medications. New physician orders will be audited by the IDT for the next following 60 days to ensure appropriate diagnosis and frequency for prescribed antidepressant medications.	

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F 281	Continued From page 30 #2 was if a resident should be left unattended with a nebulizer treatment in place. LPN #2 stated, "No, we should stay with them." LPN #2 was then asked if a resident is confused should the nurse leave the resident unattended with a nebulizer treatment in place. LPN #2 stated, "Absolutely not." An interview was conducted with RN (registered nurse) #5 on 5/20/15 at 5:40 p.m. When asked if a nurse can leave a resident unattended with a nebulizer treatment in place, RN #5 stated, 'No, we have to stay with them." An interview was conducted with the director of nursing (DON) on 5/20/15 at 5:552 p.m. The DON was asked if a nurse can leave a confused resident unattended with a nebulizer treatment in place. The DON stated, "No we they shouldn't leave any person with a neb (nebulizer) treatment in place." The DON was made aware of the above findings. The facility policy, "Respiratory: Nebulizer Mist Therapy" documented in part, "14. Switch aerosol unit on and direct patient to inhale mist slowly and deeply. 15. Continue until prescribed medication has been aerosolized from chamber." According to "Potter, Patricia A., and Anne Griffin Perry. Fundamentals of Nursing: Concepts, Process, and Practice", 4th ed. St Louis: Mosby-Year Book, Inc., 1997: "Medications of any sort should not be left unattended, and all patients should be observed taking the medication. This avoids the disposal, hoarding, abuse, or misuse of the medication, and assures the safety of the patient." No further information was provided prior to exit.	F 281	IV. Results of these audits will be reviewed by the Administrator and submitted to the facility's QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits or action plans. V. 7/6/15	

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* All medical definitions are taken from Barron's Dictionary of Medical Terms for the Non Medical Reader, 5th edition; Rothenberg and Chapman.
** This information was obtained from the website: http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682145.html

b. The facility staff failed to clarify an order for an as needed antidepressant, Trazadone for Resident #12.

Review of the hospital discharge medication list dated 4/27/15 at 8:07 p.m. documented, "Trazodone 50 mg (milligrams) tablet; take 0.5 tablets (half a tablet) (25 mg total) by mouth nightly as needed for sleep."

The facility admission orders dated, 4/27/15 and signed by the physician on 4/27/15, documented, "Trazodone; give 25 mg by mouth at bedtime for sleep."

A new physician order entered in the computer on 4/28/15, documented, "Trazodone; give 25 mg by mouth every 24 hours as needed for depression. Give nightly." There was no corresponding telephone physician order for this change in indication.

Review of the MAR (medication administration record) for April and May 2015 did not document the Trazodone had been administered.

The comprehensive care plan dated, 4/28/15, documented, "Focus: At risk for changes in mood r/t (related to) depression." The "Interventions/Tasks" documented, "Administer medications per physician orders."

A review of the clinical record did not reveal any documentation that the resident was on any other anti-depressant medications.

An interview was conducted with RN (registered nurse) #3 on 5/20/15 at 11:16 a.m. When asked if

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an anti-depressant medication can be on an as needed basis, RN #3 stated, "Not usually." RN #3 reviewed the order for Trazodone for Resident #12. She stated, "That order should have been clarified or the indication for it changed. Trazodone can be given for sleep, not just as an anti-depressant."
An interview was conducted with the director of nursing (DON) on 5/20/15 at 11:36 a.m. When asked if it is acceptable to have an anti-depressant on an as needed basis, the DON stated, "No." The order for the Trazodone was reviewed with the DON. The DON stated, "His daughter is very involved in his care. She did not like the idea that he was so sedated when he came here. She didn't want him to have the medication on a daily basis. It was ordered for sleep, not depression." When asked if the order is a valid order, the DON stated, "It is there but that's not correct. The order needs clarification."
The facility policy, "Reordering, Changing and Discontinuing Orders" documented, "3. Change Orders: Any request to change an existing order should be treated by Facility as a new order, with a corresponding cancellation of the previous order. Facility staff cannot alter directors on any existing prescription once it has been dispensed to the resident."

According to Fundamentals of Nursing, 6th edition Potter and Perry, 2005, page 846, "A medication order is required for any medication to be administered by a nurse...If the medication order is incomplete, the nurse should inform the prescriber and ensure completeness before carrying out any medication order."

The administrative team was made aware of these findings on 5/20/15 at 6:12 p.m.

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F 329	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure the drug regimen for two of 34 residents in the survey sample, (Residents #12 and #10), was free from unnecessary drugs. 1. The facility staff failed to monitor Resident # 12's blood pressure as ordered by the physician	F 329	F329 It is the practice of this facility to ensure the drug regimen is free from unnecessary drugs. I. The medication administration record (MAR) for resident #12 was updated to include "HOLD FOR SBP < 110" for the Bystolic medication on 5/20/15. An assessment of resident #12's blood pressure was performed and the physician was notified of the order omission. II. Residents prescribed blood pressure medications with parameters used to determine administration of the medication have the potential to be affected by this alleged deficient practice. An audit of residents receiving blood pressure medications was conducted to ensure appropriate physician ordered parameters were included with the order on the MAR MARs were audited for the past 30 days to ensure parameters are followed when administering blood pressure	

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prior to administering, Bystolic, a medication used to treat high blood pressure. (1)

2. The facility staff administered Metoprolol (a medication used to treat high blood pressure) when the heart rate was below the physician's ordered parameter for Resident #10.

The findings include:

1. Resident #12 was admitted to the facility on 4/27/15 with diagnoses that included but were not limited to: muscle weakness, low thyroid, anemia, dysphagia (difficulty swallowing*) high blood pressure, encephalopathy (any brain disorder*) urinary retention, and Parkinson's disease (a slowly progressing neurological disorder).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, coded the resident has having both short and long term memory difficulties and severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living.

The physician orders dated, 4/27/15, and signed by the physician on 4/27/15, documented, "Bystolic (1) Tablet 5 mg (milligrams); give 5 mg by mouth one time a day for HTN (hypertension - high blood pressure) HOLD FOR SBP (systolic blood pressure) < (less than) 110."

(1) Bystolic is used to lower high blood pressure.

The comprehensive care plan dated, 4/28/15, documented, "Focus: Cardiac disease related to

medications. Any errors were addressed appropriately.

III.
Education was provided to Licensed Nurses regarding following physician orders and ensuring parameters are followed when administering blood pressure medications by the Quality Assurance Consultant and the ADNS or her designee. The ADNS or her designee will audit the MAR of patients receiving blood pressure medications 5 times weekly for 4 weeks and weekly thereafter for an addition 2 months to ensure parameters are followed as ordered and documented.

IV.
Results of the audits will be reviewed by the Administrator and submitted to the facility's QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits or action plans.

V.
7/6/15

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hypertension, CAD (coronary artery disease)." The "Interventions/Tasks" documented, "Administer medication per physician order. Notify physician if heart rate less than 50. Obtain vital signs as indicated, report changes to physician."

Review of Resident #12's MARs (medication administration records) for April and May 2015 documented, "Bystolic Tablet 5 mg (milligrams); give 5 mg by mouth one time a day for HTN (hypertension - high blood pressure) HOLD FOR SBP (systolic blood pressure) < (less than) 110." The MARs documented the administration time as "1700 (5:00 p.m.)." There was no block on the MAR for the blood pressure readings.

Review of the "Blood Pressure Summary" in the clinical record documented blood pressures for 10 readings. Only one reading was documented near the 5:00 p.m. hour.

Review of the nurse's notes from 4/27/15 through 5/20/15 was conducted. The blood pressure was documented only 22 times. Of those 22 times, 14 were on the day shift, not at the time the Bystolic was prescribed. The facility has three shifts of nurses per day.

An interview was conducted with RN (registered nurse) #3 on 5/20/15 at 11:16 a.m. regarding physician ordered parameters for administration of a medication. RN #3 stated, "If there are parameters, say for blood pressure medications, you need to take the blood pressure prior to administering the blood pressure." When asked where the blood pressure is documented, RN #3 stated, "The computer prompts you to enter in the blood pressure and if it doesn't, the nurse has to

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document it in the nurse's notes."

An interview was conducted with the director of nursing (DON) on 5/20/15 at 11:36 a.m. regarding physician ordered parameters for administration of a medication. The DON stated, "The nurse has to take the pulse or blood pressure or whatever parameter is prescribed prior to administering the medication." When asked where this information is documented, the DON stated, "Normally, the eMAR (electronic medication administration record) prompts the nurse to record the blood pressure." When asked if it isn't documented on the MAR where it would be documented, the DON stated, "The nurse should document it in a nurse's note." The MAR for Resident #12 was reviewed with the DON.

On 5/20/15 at 2:56 p.m. the usual evening shift nurse, LPN (licensed practical nurse) #2, caring for Resident #12, was interviewed. When asked where the documentation was for the blood pressure parameters for the Bystolic, LPN #2 stated, "We normally document it but it's not documented. I thought I had it in my notes but obviously I didn't." When asked if she could show she obtained the blood pressure prior to the administration of the medication, LPN #2 stated, "No, I can't."

The facility policy, Medication and Treatment Administration Guidelines" documented, "Vital signs are taken and recorded prior to the administration of vital sign dependent medications in accordance with the physician orders."

According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35,

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"Medication Administration" Chapter 35, pg 707 read: "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication, 2. The right dose, 3. The right client, 4. The right route, 5. The right time, and 6. The right documentation." Under the subheading Right Route (on pg. 708) "....When administering injections, precautions are necessary to ensure the nurse gives the medications correctly...."

The administrative team was made aware of these findings on 5/20/15 at 6:12 p.m.

(1) This information was obtained from the website: http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=8B8AD213-1DC8-454E-A524-075685C0E1A8

* All medical definitions are taken from Barron's Dictionary of Medical Terms for the Non Medical Reader, 5th edition; Rothenberg and Chapman.
2. The facility staff administered metoprolol (a medication used to treat high blood pressure) when the heart rate was below the physician's ordered parameter for Resident #10. Resident #10 was admitted to the facility on 6/17/14 with diagnoses that included but not limited to: dementia, insomnia, high blood

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pressure and lumbar (back bone) fracture. The most recent MDS (minimum data set), a quarterly review, dated 3/27/15 coded the resident as being severely impaired cognitively.

A physician's order dated and signed on 3/22/15 documented, "Metoprolol 50 mg (milligrams) BID (twice a day), hold for SBP (systolic blood pressure) < (less than) 110 or HR (heart rate) < 60."

A review of the MAR (medication administration record) documented on 4/24/15 at 10:00 a.m. the resident's heart rate as 58 and the metoprolol was documented as being administered. On 5/7/15 at 10:00 a.m. the resident's heart rate was documented as 57 and the metoprolol was documented as being administered. On 5/14/15 at 10:00 a.m. the resident's heart rate was documented as 56 and the metoprolol was documented as being given.

An interview was conducted on 5/20/15 at 2:15 p.m. with LPN (licensed practical nurse) #6 and ASM (administrative staff member) #3, Quality Assurance RN (registered nurse). LPN #6 was asked to review Resident #10's MAR for the administration of metoprolol. LPN #6 read the parameters ordered for the metoprolol and was asked to review the MAR for 5/7/15 at 10:00 a.m. LPN #6 was asked if the metoprolol should have

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F 329	Continued From page 39 p.m. with ASM #2, the director of nursing. When asked what process the nurses followed for administering medications, ASM #2 stated, "We do the five rights, the right dose, right medication, right patient, right time, right route and of course we review any parameters." ASM #2 reviewed the MAR and was made aware of the findings. No further information was provided prior to exit. Nursing 2010 Drug Handbook; Lippincott, Williams & Wilkins, page 387, documented, "Nursing Considerations: Always check patient's apical pulse rate before giving drug. If it's slower than 60 beats/minute, withhold drug and call prescriber immediately."	F 329		
F 360 SS=D	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to meet the special dietary needs of one of 34 residents, Resident #16 Resident # 16, who was Muslim, was served ham as part of her meal on two occasions which is prohibited by Muslims. The findings include: Resident # 16 was admitted to the facility on 3/14/14 with diagnoses that included but were not limited to malaise (a generalized feeling of	F 360	F360 It is the practice of this facility to provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. I. The tray ticket for resident #16 was reviewed to ensure the preference of NO PORK was indicated on 5/20/15. II. Residents with special dietary preferences have the potential to be affected by this alleged deficient	

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F 360	Continued From page 40 discomfort, illness, or lack of well-being) and fatigue, hypertension (high blood pressure), esophageal reflux (when a muscle at the end of your esophagus does not close properly it allows stomach contents to leak back, or reflux, into the esophagus and irritate it), anemia (low iron), depressive disorder, cerebral vascular accident (stroke), hyperlipidemia (high cholesterol) and neuropathy (nerve damage). The most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/22/15, coded the resident as being severely impaired of cognition for daily decision making. Resident # 16 was coded as requiring extensive assistance of one staff member for all activities of daily living. The POSs (physician's order sheets) dated September 2014, December 2014, April 2015 and May 2015 documented, "Allergies: penicillins, pork." Further review of the POSs revealed Resident # 16's diet was regular. Resident # 16's care plan dated 3/18/14 was reviewed. Under the heading "Interventions" it documented, "Honor food preferences. Date initiated 3/18/14. Provide diet as ordered, no pork. Date initiated 3/18/14." Resident # 16's meal ticket was reviewed. The meal ticket documented in part, "Allergies / Sensitivities: Pork." The "Progress Note" by social services dated 9/29/14 documented in part, "Care conference review: The son and resident was invited to the conference but did not attend. The IDT (interdisciplinary team) was present and discussed the resident's progress on her treatment plan ...The son had concerns about the food and diet in which the food services director addresses each of his concerns ..." The facility's "Concern Form" completed and	F 360	practice. An audit of resident dietary preferences was reviewed for accuracy and corrections were made as appropriate. III. Dietary staff were educated by the Food Service Director (FSD) on the importance of following the food preferences indicated on the tray ticket at the time of the tray preparation. The FSD or her designee will audit completed meal trays 5 times a week for 4 weeks and 3 times a week for the next 60 days to ensure compliance. IV. Results of the audits will be reviewed by the Administrator and submitted to the facility's QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits or action plans. V 7/6/15	

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signed by OSM (other staff member) # 5 social worker dated 9/29/14 was reviewed. Under "Documentation of Concern" it documented, "Son stated that his mother was served pork twice for dinner." Under "Documentation of Facility Follow-up" it documented, "Spoke to son with social services present. Resident placed on kitchen concern board." Under "Resolution of Concern" it documented, "Continued education of staff."

The facility's "Concern Form" completed and signed by ASM (administrative staff member) # 1, the administrator dated 12/11/14 was reviewed. Under "Documentation of Concern" it documented, "Mom received ham sandwich for dinner." Under "Documentation of Facility Follow-up" it documented, "Apologized and obtained a different meal. Explained that the resident/family Christmas party was taking place and that box dinners were sent to those not wishing to attend." Under Resolution of Concern" it documented, "Unknown- could not determine if son accepted my sincere apology."

On 5/21/15 at 7:55 a.m. an interview was conducted with OSM (other staff member) # 8 the dietician and OSM # 9 the food service director. When asked how residents are identified that may have dietary restrictions or preferences due to their religion or culture, OSM # 8 stated that they conduct a preference assessment with the resident and or family upon admission to the facility. OSM # 9 stated the resident's preferences or restrictions are put on the resident's meal ticket and it is highlighted before the tray line serves the food. When asked how they ensure a resident's preference is being honored, OSM # 8 and OSM # 9 stated that the staff is to read the resident's meal ticket. When asked if they were aware of Resident # 16's

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request not to be served pork, they stated yes. A request by this surveyor was then made for a copy of Resident # 16's interview regarding the food preferences. On 5/21/15 at 12:15 p.m. OSM # 8 stated that at the time of Resident # 16's admission into the facility there was another food service director who was currently no long employed with the facility. OSM # 8 stated that they were unable to locate the preference assessment for Resident # 16.

On 5/21/15 at approximately 11:00 a.m. an interview was conducted with OSM # 5, the social worker. OSM # 5 was asked to review the facility's "Concern Form" dated 9/29/14. When asked if she had completed the concern form and if she recalled the concern expressed by Resident # 16's son, OSM # 5 stated, "Yes." OSM # 5 stated that she was informed of Resident # 16 receiving pork as part of her meal at the care conference (care plan) meeting by Resident # 16's son on 9/29/14. OSM # 5 stated that the incident had occurred a couple of days before the care conference meeting. OSM # 5 stated that after the meeting she met with the son and OSM # 13, the food service director at that time (who was no longer at the facility), regarding the son's concern of Resident # 16 receiving pork as part of her meal. OSM # 5 stated that the son explained that Resident # 16 was unable to eat pork as part of their religious and cultural practice of being Muslim. OSM # 5 further stated that OSM # 13 stated they would provide education to the kitchen staff regarding Resident #16's preference not to have pork as part of the meals. OSM # 5 stated that the son was satisfied with the proposed resolution.

On 5/21/15 at 12:50 p.m. an interview was conducted with ASM # 1, the administrator. ASM # 1 was asked to review the facility's "Concern

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F 360	Continued From page 43 Form" dated 12/11/14. When asked if she had completed the concern form and if she recalled the concern expressed by Resident # 16's son, ASM # 1 stated, "Yes." When ASM # 1 was asked to describe the incident, ASM # 1 stated, "There was a note on Resident # 16's meal ticket that she was not to have pork. I took the meal back to the kitchen staff and told them they needed to pay attention to the resident's meal ticket. I obtained a chicken dinner and gave it to the resident." ASM # 1 further stated that she has not heard of any concerns regarding pork from Resident # 16's son since 12/11/14. The Administrator was made aware of the findings on 5/21/15 at approximately 2:10 p.m. No further information was provided prior to exit.	F 360		
F 371 SS=F	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 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to prepare, store and serve food in a sanitary manner.	F 371	F371 It is the practice of this facility to prepare and serve food in a sanitary manner. I. Staff member #2 and #3 were educated regarding the use of facial hair restraints on 5/22/15 by the Food Service Director. There was no specific resident identified as being affected by this alleged deficient practice. II. Residents residing in the facility	

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F 371	Continued From page 44 Two male Dietary Aides (OSM #1, OSM #2) were observed preparing lunches without wearing hair restraints on their beards and moustaches. The findings include: On 5/19/15 at 12:40 P.M. an observation was made of the kitchen. The tray line process was observed. Staff were plating lunches for the residents. The Food Services Manager, OSM #3 (Other Staff Member #3) was present during the kitchen tour. Two male Dietary Aides (OSM #1, OSM #2) were observed preparing lunches without wearing hair restraints on their beards and moustaches. OSM #1's beard that was approximately 1 inch long, and a moustache that was approximately 1/4 inch long. OSM #2's beard was approximately 1 inch long, and his moustache was about 1/4 inch long. On 5/19/15 at 12:50 P.M., an interview was conducted with the Food Services Manager (OSM #3). When asked why the staff did not have on beard restraints, OSM #3 stated, "They usually have the restraints on their beards and moustaches, they don't have them on because we ran out. We ordered them. They should be here by Friday or Tuesday. No one told me that we were running out of them." When asked to state the importance of wearing hair restraints, she stated, "To keep the hair from falling in the plate. To prevent the possibility of Residents opening up the plate and seeing hair laying there, and also to prevent infection." On 5/19/15 at 1:30 P.M. another interview was	F 371	have the potential to be affected by this alleged deficient practice. III. Dietary staff were educated by the Food Service Director (FSD) on the use of hair restraints on their facial hair. The FSD or her designee will audit the use of hair restraints 5 times per week for 4 weeks and 3 times per week for the following 8 weeks to ensure compliance. IV, The audits will be reviewed by the Administrator and the results of the audits will be presented to the facility's QAPI committee for review and actions as appropriate. The QAPI committee will determine the need to further audits or action plans. V. 7/6/15	

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F 371	Continued From page 45 conducted with OSM #3, in the conference room. She stated, "I did find some beard restraints in the bottom of the box under the regular hair restraints." On 5/20/15 at 10:30 A.M. another observation was conducted of the kitchen. The Dietary Services Manager (OSM #3) was present. The Dietary Aide (OSM #1) had a beard restraint down around his neck. He pulled the restraint over his beard and moustache after being directed to do so by the Dietary Services Manager. On 5/20/15 at 10:32 A.M. an interview was conducted with the Dietary Services Manager (OSM #3), and the Dietary Aide. The Dietary Services Manager stated, "I told him to put it on. He was washing dishes." When asked why he did not have the restraint on, the Dietary Aide stated, "It's on properly now." On 5/20/15 a review was conducted of facility documentation, revealing a Hair Restraint policy dated 4/7/06. The Dietary Services Manager stated that the policy was still in effect. It read, "Guidelines - Hair restraints are worn by anyone in the kitchen. Hair restraints include beard or facial hair coverings." On 5/20/15 at 3:30 P.M. the facility Administrator was informed of the findings. No further information was received.	F 371		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,	F 465	F465 It is the practice of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	

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F 465	Continued From page 46 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to store chemicals in a safe manner in one of three janitor closets. The janitor's closet on Unit one containing disinfectant cleaner, disinfectant spray and window cleaner was left unlocked. The findings include: Observation of the facility's janitor closet door on Unit one on 5/20/15 at 9:05 a.m. revealed a key pad lock mounted on the outside of the door. Upon pushing on the door, the door opened without depressing any of the numbers on the key pad to unlock the door. Observations of the interior of the closet revealed access to a wall mounted chemical dispenser. Further observation of the chemical dispenser revealed it contained disinfectant cleaner, disinfectant spray and window cleaner. During the days of the survey no residents were observed entering the janitor's closet on Unit one. On 5/21/15 at approximately 12:10 p.m. an interview was conducted with OSM (other staff member) # 12, director of housekeeping regarding the access to the janitors closet on Unit one. OSM # 13 stated that the janitor's closet should be locked at all times. The MSDS (Material Safety Data Sheet) for	F 465	I. The janitor's closet door on Unit 1 was adjusted to ensure it closes securely on 5/20/15. II. Janitor closets throughout the facility were inspected to ensure they close securely on 5/20/15. III. Staff were educated on the importance to ensuring areas containing harmful chemicals are secured and locked by the Administrator. The Administrator or her designee will conduct unit audits to ensure areas are secured 5 times per week for 4 weeks and twice per week for the following 60 days to ensure compliance. IV. Results of the audits will be presented to the facility's QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits or action plans. V. 7/6/15	

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F 465	Continued From page 47 "A-456 II Disinfectant Cleaner" documented, "Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage." The MSDS (Material Safety Data Sheet) for "Disinfectant Spray for Hospital Use" documented, "Moderately irritating to the eyes. Harmful if absorbed through the skin. Repeated or prolonged skin contact may cause allergic reactions with susceptible persons. Intentional misuse by concentrating and inhaling the product can be harmful or fatal. Prolonged inhalation may be harmful." The MSDS (Material Safety Data Sheet) for "Windex Original Glass Cleaner With Ammonia-D" documented, "Avoid contact with skin, eyes and clothing." The Administrator was made aware of the findings on 5/21/15 at approximately 2:10 p.m. No further information was provided prior to exit.	F 465		
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, facility document review and clinical record review, it was determined that the facility staff failed to obtain laboratory tests per physician's orders.	F 502	F502 It is the practice of this facility to obtain laboratory services to meet the needs of its residents. I. A physician order for fasting lipid profile, CBC and BMP was added to the physician orders on 5/21/15 for resident #2. II. Residents with recurring laboratory orders have the potential to be	

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F 502	Continued From page 48 The facility staff failed to obtain a fasting lipid profile*, CBC (complete blood count) ** and BMP (basic metabolic panel) ***, ordered by the physician on 8/20/14 to be completed every six months. The findings include: Resident #2 was admitted to the facility on 10/14/12 and readmitted on 8/19/14 with diagnoses that included but were not limited to diabetes (a blood sugar disorder), glaucoma (an eye disease) and high cholesterol. Resident #2's most recent MDS, an annual assessment with an ARD of 3/11/15, coded the resident as being understood and as understanding verbal content. Section C coded Resident #2 as being cognitively intact. Review of Resident #2's clinical record revealed a physician's order summary signed by the physician on 8/20/14 that documented orders for a fasting lipid panel, a hemoglobin A1c****, a CBC and a BMP every six months. Further review of Resident #2's clinical record revealed the results of a hemoglobin A1c dated 3/19/15 but failed to reveal results of a fasting lipid panel, CBC or BMP from 8/20/14 through the beginning of the survey (5/19/15). Resident #2's comprehensive care plan initiated on 3/26/14 documented, "Focus: Hematological (blood) condition r/t (related to) anemia*****...Interventions/Tasks: Obtain Lab results as ordered and notify physician of results...Focus: Risk for alteration in hydration related to diuretics******...Interventions/Tasks: Obtain Lab results as ordered and notify physician of results..."	F 502	affected by this alleged deficient practice. An audit was conducted to identify residents with recurring laboratory to ensure orders are present and active. Corrections were made as appropriate. III. Education was provided by the Administrative Director of Nursing Services (ADNS) and Director of Care Delivery (DCD) to Licensed Nurses regarding entering recurring lab orders into the electronic order system, lab tracking and the use of the lab tracking tool. The ADNS or her designee will review new laboratory orders 5 times per week for 4 weeks and then weekly for 8 weeks to ensure orders are entered correctly and documented on the lab tracking tool. The lab tracking tool will be audited 5 times weekly for 4 weeks and then weekly for an additional 8 weeks to ensure compliance with this plan. IV. Results of the audits will be reviewed by the Administrator and submitted to the facility's QAPI	

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F 502	Continued From page 49 On 5/20/15 at 6:15 p.m., the administrator and director of nursing were made aware of the above findings. On 5/21/15 at 7:30 a.m., the director of nursing confirmed the above labs were not completed. On 5/21/15 at 7:55 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated when a physician writes an order for labs, the nurses document the order in the computer and there is an option to select every six months to write under the order. RN #1 stated the nurses have a lab tracking book that they check every day and the order will also pop up in the computer. The facility document titled, "LABORATORY TRACKING GUIDELINES" documented in part, "PURPOSE: To establish guidelines to track the completion, reporting and monitoring of laboratory (lab) tests and results...GUIDELINES: Lab tests and, or services are provided: when specifically ordered by the attending physician or physician extender..." *"The lipid profile is used as part of a cardiac risk assessment to help determine an individual's risk of heart disease and to help make decisions about what treatment may be best if there is borderline or high risk." This information was obtained from the website: http://labtestsonline.org/understanding/analytes/lipid/tab/test **"A complete blood count (CBC) is used to detect or monitor many different health conditions. It may be used to: diagnose infections or allergies, detect blood clotting problems or	F 502	committee for review and action as appropriate. The QAPI committee will determine the need for further audits or action plans. V. 7/6/15	

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F 502	Continued From page 50 blood disorders, including anemia, and evaluate red blood cell production or destruction." This information was obtained from the website: http://www.nlm.nih.gov/medlineplus/ency/article/003642.htm ***"The basic metabolic panel (BMP) is used to check the status of a person's kidneys and their electrolyte and acid/base balance, as well as their blood glucose level." This information was obtained from the website: http://labtestsonline.org/understanding/analytes/bmp/tab/test ****"The A1c test is used to monitor the glucose control of diabetics over time." This information was obtained from the website: http://labtestsonline.org/understanding/analytes/a1c/tab/test *****"If you have anemia, your blood does not carry enough oxygen to the rest of your body. The most common cause of anemia is not having enough iron. Your body needs iron to make hemoglobin. Hemoglobin is an iron-rich protein that gives the red color to blood. It carries oxygen from the lungs to the rest of the body." This information was obtained from the website: http://www.nlm.nih.gov/medlineplus/anemia.html ******"Diuretics help your body get rid of extra fluid. They are often called "water pills." This information was obtained from the website: http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000112.htm.	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514	F514 It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices. I. The location of pain for resident #4 will be documented at the time of as needed pain medication	

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F 514	Continued From page 51 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 document review, clinical record review it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 34 residents in the survey sample, (Resident # 4). The facility staff failed to document the location of Resident # 4's pain prior to administering as needed pain medication. The findings include: Resident # 4 was admitted to the facility on 12/22/11 with a readmission on 9/22/14 with diagnoses that included but were not limited to: anemia (low iron), hypertension (high blood pressure), depression, dementia (a group of symptoms caused by disorders that affect the brain), diabetes mellitus (a disease in which your blood glucose, or blood sugar, levels are too high), schizophrenia, end stage renal disease, legal blindness, atrial fibrillation (irregular heart beat), esophageal reflux (when a muscle at the end of your esophagus does not close properly it allows stomach contents to leak back, or reflux, into the esophagus and irritate it) and venous insufficiency. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment	F 514	administration. II. Resident receiving as needed pain medication have the potential to be affected by this alleged deficient practice. An audit of residents with MD orders for as needed pain medication was conducted to ensure the MD order was appropriate. Medications were changed or deleted for non-use as appropriate. III. Education was provided to Licensed Nurses related to the appropriate documentation needed when administering an as needed pain medication to include the location of the pain. This education was provided by the Administrative Director of Nursing Services (ADNS). The ADNS or her designee will conduct audits of the MAR and Nurse's Notes for patients prescribed as needed pain medication. The audits will occur 5 times weekly for 30 days and then weekly for the next 60 days to ensure compliance with this plan.	

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F 514	Continued From page 52 reference date) of 4/2/15, coded the resident as being severely impaired of cognition for daily decision making. Resident # 4 was coded as requiring extensive assistance of one staff member for all activities of daily living. The nurse's notes for Resident # 4 dated 2/2/15, 2/6/15, 2/7/145 2/9/15, 4/20/15, 4/21/15, 4/25/15, 5/4/15 and 5/13/15 revealed Resident # 4 received as needed pain medication, *vicodin 5-300 milligram. Further review of the nurse's notes failed to evidence documentation of the location of Resident # 4's pain. The eMARs (electronic medication administration records) dated February 2015, April 2015 and May 2015 documented, "Vicodin Tablet 5-300 mg (milligram) [Hydrocodone-Acetaminophen]. Give 1 (one) tablet by mouth every 8 (eight) hours as needed for pain give 1 (one) tablet three times a daily as needed for pain; not to exceed a total Tylenol dose of 3 (three) grams a day." Review of the eMARs dated February 2015, April 2015 and May 2015 revealed Resident # 4 receiving as needed pain medication on 2/2/15, 2/6/15, 2/7/145 2/9/15, 4/20/15, 4/21/15, 4/25/15, 5/4/15 and 5/13/15. Further review of the eMARs failed to evidence documentation of the location of Resident # 4's pain. On 5/20/15 at approximately 10:00 a.m. an interview was conducted with LPN (licensed practical nurse) # 3, unit manager about documenting the location of pain for a resident who is nonverbal. LPN # 3 stated that the nurse's use the resident facial expressions and vital signs to determine the intensity of the resident's pain. The nurse tries to ascertain where the resident's pain is. When asked if and where the nurse is suppose document the location of the resident's pain LPN # 3 stated, "Yes it should be in the nurse's notes, it is part of the assessment for	F 514	IV. The results of the audits will be reviewed by the Administrator and submitted to the facility's QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits or action plans. V. 7/6/15	

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F 514	Continued From page 53	F 514		

pain." LPN # 3 was then asked to review the nurse's notes dated 2/2/15, 2/6/15, 2/7/145 2/9/15, 4/20/15, 4/21/15, 4/25/15, 5/4/15 and 5/13/15. After reviewing the nurse's notes LPN # 3 was asked if the location of Resident # 4's pain was documented. LPN # 4 stated, "I know they're doing it they just forgot to put it in the notes."

On 5/21/15 at approximately 8:05 a.m. an interview was conducted with LPN # 8. After reviewing the nurse's note dated 4/21/15, LPN # 8 was asked if she had administered the as needed pain medication to Resident # 4 and if she wrote the note. LPN # 8 stated, "Yes." When asked about documenting the location of the resident's pain, LPN # 8 stated, "I try to locate where the pain is and document it in the notes." After reviewing the nurse's note dated 4/21/14, LPN # 8 stated, "I did try to identify where the resident's pain was but I didn't document it."

On 5/21/15 at approximately 10:45 a.m. an interview was conducted with the Director of Nursing (DON) about documenting the location of the resident's pain. After reviewing the nurse's notes dated 2/2/15, 2/6/15, 2/7/145 2/9/15, 4/20/15, 4/21/15, 4/25/15, 5/4/15 and 5/13/15 the DON the DON stated, "They should be documenting the location of the pain in the nurses notes. They're doing it but not documenting it."

Review of the facility's policy "Medication Management Guidelines: Documentation" revealed nothing pertinent to these findings.

The Administrator was made aware of the findings on 5/21/15 at approximately 2:10 p.m. No further information was provided prior to exit.

* Vicodin (Hydrocodone-Acetaminophen) - drugs that are mostly used to treat extreme pain. Taken from: http://www.nlm.nih.gov/medlineplus/ency/article/007285.htm.

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F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 5/19/15 through 5/21/15. Corrections are required for compliance with 42CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 155 certified bed facility was 132 at the time of the survey. The survey sample consisted of 27 current Resident Reviews (Residents #1 through #21 and #29 through #34) and 7 closed record reviews (Residents #22 through #28).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5 - 371 - 110 B.3. cross references to F 226 12 VAC 5 - 371 - 140 E3b cross references to F 226 12 VAC 5 - 371 - 250 F, G cross references to F 279 12 VAC 5 - 371 - 220 B cross references to F 281 and F 329 Dietary and Food Service Program 12 VAC 5-371-340 (A). Please Cross-Reference to F-371. Maintenance and Housekeeping F465 cross reference 12VAC5-371-370A Clinical records	F 001	12 VAC5-371-110 B.3 Cross reference plan of correction for F226 12 VAC5-371-140E3b Cross reference plan of correction for F226 12 VAC5-371 250 F, G Cross reference plan of correction for F279 12 VAC5-371 220 B Cross reference plan of correction for F329 12 VAC5-371-340 (A) Cross reference plan of correction for F371 12 VAC5-371-370A Cross reference plan of correction for F465 12VAC5-371-360F9 Cross reference plan of correction for F514 12VAC5-371-310 Cross reference plan of correction for F502	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samantha Dawn Wilbert	Admin	6-12-15

State of Virginia

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F514 cross reference 12VAC5-371-360F9

12VAC5-371-310. Diagnostic services cross reference to F502.

12VAC5-371-140. Policies and procedures. (amended 9/2011)

Virginia Nursing Home Regulation 12VAC5-371-140 states

"B. All policies and procedures shall be reviewed at least annually, with recommended changes submitted to the governing body for approval."

And:

D. Administrative and operational policies and procedures shall include, but are not limited to:
1. Administrative records;
2. Admission, transfer and discharge;
3. Medical direction and physician services;
4. Nursing direction and nursing services;
5. Pharmaceutical services, including drugs purchased outside the nursing facility;
6. Dietary services;
7. Social services;
8. Activities services;
9. Restorative and rehabilitative resident services;
10. Contractual services;
11. Clinical records;
12. Resident rights and grievances;
13. Quality assurance and infection control;
14. Safety and emergency preparedness procedures; and
15. Professional and clinical ethics, including:
a. Confidentiality of resident information;
b. Truthful communication with residents;
c. Observance of appropriate standards of informed consent and refusal of treatment; and

12VAC5-371-140
It is the practice of this facility to conduct an annual review of policies and procedures and present recommended changes to the governing body for approval.

I.
No specific resident was identified to be affected by this alleged deficient practice.

II.
Residents residing in the facility have the potential to be affected by the alleged deficient practice.

III.
An ad-hoc QAPI committee meeting was conducted to review the Administrative and Operational Policies and Procedures to include Administrative records, physician services, rehabilitation services, contractual services, safety and emergency, facility security, confidentiality of information and dignity preservation. Education was provided to the members of the QAPI committee related to the requirement of annual policy and

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d. Preservation of resident dignity, with special attention to the needs of the aged, the cognitively impaired, and the dying; and
16. Facility security.

On 5/20/15 at approximately 2:00 p.m. the Administrator provided a "Quality Assessment and Assurance Committee Meeting Minutes Tool" dated 2/11/5 which identified policy review for the following policies: Clinical, Infection Control, Nursing Procedures, Patient Protection, Housekeeping, Social Services, Dietary, and QAPI.

Per the requirement of 12VAC5-371-140. Policies and procedures, policy review for Administrative records, admission/transfer/discharge, Physician Services, Pharmacy Services, Activity Services, Rehab (rehabilitation) Services, Contractual Services, Clinical Records, Resident Rights and Grievances, Safety and Emergency, Facility Security, Confidentiality of Information, and Dignity Preservation, was requested from the Administrator on 5/20/15 at approximately 2:15 p.m. At approximately 2:45 p.m., she stated that Admission/transfer/discharge was included in social services; and resident rights and grievances was included in clinical policies as well as social services. She further stated that reviews were not completed for pharmacy, activities, and clinical record. She was not able to locate policies for Administrative records, physician services, rehab (rehabilitation) services, contractual services, safety and emergency, facility security, Confidentiality of information, and dignity preservation.

No further information was provided by the end of the survey.

procedure review. An annual recurring entry was made into the calendar of committee members to ensure annual review of policies and procedures.

IV.
This plan will be reviewed by the facility's QAPI committee to ensure sustainability.

V.
7/6/15

State of Virginia

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