STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495011	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ALEXANDRIA	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(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 8/9/16 through 8/11/16. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 96 certified bed facility was 79 at the time of the survey. The survey sample consisted of 14 current resident reviews (Residents #1 through #13 and #20) and 6 closed record reviews (Residents #14 through #19).	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	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	

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AUG 29 2016
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Manorcare	ADMINISTRATOR	August 26, 2016

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 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to report three allegations of abuse to the state agency for three of 20 Residents, Residents #12, #2, and #19. 1. The facility staff failed to implement the reporting guidelines (required by state law) to submit an initial and follow-up report to the state agency after an allegation of abuse by Resident # 12. 2. The facility staff failed to implement the reporting guidelines (required by state law) to submit an initial and final report to the state agency in the required time frame after a reported allegation of abuse for Resident # 2. 3. The facility staff failed to implement the reporting guidelines (required by state law) to submit an initial and final report to the state	F 225	corrected by the date or dates indicated. **F225** It is the practice of the facility to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator and to other officials in accordance with State law through established procedures (including to the	

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F 225	Continued From page 2 agencies, the Virginia Department of Health and the Department of Health Professionals in the required time frame after a reported allegation of abuse for Resident #19. The findings include: 1. The facility staff failed to implement the reporting guidelines (required by state law) to submit an initial and follow-up report to the state agency after an allegation of abuse by Resident # 12. Resident # 12 was admitted to the facility on 5/12/15 and readmitted on 3/16/16 with diagnoses that included: osteoarthritis, peripheral neuropathy, diabetes, coronary artery disease and angina. Resident # 12's most recent MDS (minimum data set) assessment, an Annual Assessment, with an ARD (assessment reference date) of 5/22/16 coded Resident # 12 as understood by others and as able to understand others. Resident # 12 was coded on the BIMS (Brief Interview for Mental Status) with a score of 12 out of 15, indicating that the Resident is cognitively intact. During the survey process the FRIs (facility reported incidents) were requested. No FRIs were presented but instead "Concern Forms" were presented. A "Concern Form" for Resident # 12 was reviewed. The "Concern Form" for Resident # 12 documented that on 7/25/16 Resident # 12 went to (name of nurse) to remind her about a medication. Resident # 12 related that the nurse started yelling at her (Resident #12). Resident # 12 reported that the nurse was rude and insulting.	F 225	State survey and certification agency). **I** **Corrective Action** Residents #2 and #12 have been reassessed for any negative impact from the alleged abuse and are found to be in stable condition and verbalized living in the facility without fear. Resident #19 no longer resides in the facility.	

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F 225	Continued From page 3 During an interview on 8/10/16 at 4:50 p.m. with ASM (administrative staff member) # 1, the administrator, ASM # 1 stated, "I did not send any report to your office (state agency) because I finished the investigation and there was no need." During this interview the policy for reporting abuse and the meaning of "immediately" reporting to the state agency were discussed. At this time a request was made for any policy (state or facility) that the facility uses as a guideline. The following state and facility policies were presented by ASM # 1 on 8/10/16 at approximately 6:00 p.m. Review of The Virginia Department of Health Office of Licensure and Certification policy "Reporting Abuse, Neglect, Misappropriation of Resident Personnel Property Or Facility Reported Incidents (FRI)" documented under, "General Rule. B. When incidences of staff misconduct occur, a federally certified facility is required to self-report those occurrences by filing an initial written report immediately to the OLC (Office of Licensure and Certification) and to any other state officials required by state law. e.g. the Adult Protective Services Unit of the Virginia Department of Social Services...NOTE: Facilities shall follow the reporting criteria of other agencies, such as APS/DSS (Adult Protective Services/ Department of Social Services) or DHP (Department of Health Professional), which may vary from this guideline." Review of the facility policy documented the following: "Patient Protection Practice Guide" under "Report/Respond ...Reporting. The center	F 225	**II** **Identification** All residents residing in the facility have the potential to be affected by the alleged deficient practice. The Administrator or designee has completed a review of all concerns since the previous survey by residents or family members and found them to be sufficiently investigated and concluded. **III** **Systemic Changes** The Administrator and other department heads would be re-educated by the Social Worker on the policies and procedures on handling allegations of	

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F 225	Continued From page 4 must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures (including to the state survey and certification agency)...The results of all investigations must to be reported to the administrator or his/her designated representative and to other officials in accordance with state law (including to the state survey and certification agency) with 5 (five) working days of the incident. CMS (Center for Medicare/Medicaid Services) defines "immediately" to mean as soon as possible, but not ought not to exceed 24 hours after discovery of the incident, in the absence of a shorter time frame requirement." No further documentation was provided prior to exit. 2. The facility staff failed to file an initial and follow-up report with the state agency in the required five days after a reported allegation of abuse for Resident # 2. Resident # 2 was admitted to the facility on 2/14/15 with diagnoses that included but were not limited to: deep venous thrombosis (1), hypertension (2), gastroesophageal reflux disease (3), urinary tract infection (4), diabetes mellitus (5), anxiety (6), depression, muscle weakness, obesity, pain, neurogenic bladder (7), and cerebral vascular accident (8). Resident # 2's most recent comprehensive MDS (minimum data set), a quarterly assessment with	F 225	abuse, including timely reporting to outside agencies. **IV** **Monitoring** The Administrator or designee would audit concerns forwarded to the Social Worker or other staff members for appropriate investigation and or reporting weekly for four weeks and once a month for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and	

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F 225	Continued From page 5 an ARD (assessment reference date) of 6/22/16, coded Resident # 2 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 2 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living. A review of the facilities "Investigation Report", dated 6/16/16 documented, "Date of incident: 6/15/16. Summary of Alleged Incident: Patient, (Resident # 2) reported an allegation of unwanted sexual advances by OSM (other staff member) # 14, who works in housekeeping and laundry during evening hours. She cited buying of makeup gifts, unsolicited neck massage, uninvited kissing to her cheeks and lips." The "Investigation Report" dated 6/17/16 documented, "Conclusion: After thorough investigation of this allegation, the IDT (interdisciplinary team) finds the resident to be credible, and given the fact that (OSM # 14) accepted that he had bought makeups for the resident as gift though they are not in any way related to each other, has sustained that resident's claim that (OSM # 14) made unwanted sexual advances towards (Resident # 2). However, given that the resident, in no way considered the action as abuse, but a concern to be handled through the facility's disciplinary process, no law enforcement agency is notified. In order to protect the resident and any other resident in the facility from such behaviors by (OSM # 14), therefore the IDT recommends the termination of (OSM # 14's) employment services in (Name of Facility) effective immediately. (OSM # 14) does not hold a license of any kind that would have warranted notification of such a	F 225	Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **9/16/2016**	

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F 225	Continued From page 6 board." Further review of the facility's "Investigation Report" dated 6/16/16 and 6/17/16 failed to evidence the initial allegation and the follow up to this incident was provided to OLC (office of licensure and certification). On 8/10/16 at 4:30 p.m. an interview was conducted with ASM (administrative staff member) # 1, the administrator. When asked why the allegation of abuse by Resident # 2 was not reported to the office of licensure and certification ASM # 1 stated, "I didn't send it because the employee was not licensed." On 8/10/16 at 5:50 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings. No further information was provided by the end of the survey. References: (1) A condition that occurs when a blood clot forms in a vein deep inside a part of the body. It mainly affects the large veins in the lower leg and thigh, but can occur in other deep veins such as in the arms and pelvis. This information was obtained from the website: https://medlineplus.gov/ency/article/000156.htm>. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (3) Stomach contents to leak back, or reflux, into	F 225		

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F 225	Continued From page 7 the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) An infection in the urinary tract. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm. (5) A chronic disease in which the body cannot regulate the amount of sugar in the blood) This information was obtained from the website: <ttps://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (6) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary (7) A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm. (8) A stroke. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000726.htm. 3. The facility staff failed to file an initial and follow-up report with the state agencies, the Virginia Department of Health and the Department of Health Professionals in the required time frame after a reported allegation of abuse for Resident # 19.	F 225		

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F 225	Continued From page 8 Resident # 19 was admitted to the facility on 3/21/16 with diagnoses that included but were not limited to: low iron, coronary artery disease (1), hypertension (2), hyponatremia (3), anxiety (4) and depression. Resident # 19's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/28/16, coded Resident # 19 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 19 was coded as requiring extensive assistance of one staff member for activities of daily living. A review of the facility's "Concern Form" dated 4/22/16 documented, "Documentation of Concern: Pt (Patient [Resident #19]) alleged inappropriate touching by staff CNA (certified nursing assistant) during transfer on 4/17/16." The "Investigation Report" dated 4/22/16 documented, "Action Taken During Investigation: The male staff named in the allegation was suspended immediately while conducting the investigation. The patient's daughter and physician were notified. Patient withdrew the allegation; therefore, no state report was initiated." Under "Conclusion" it documented, "The allegation of inappropriate touching is unsubstantiated. The patient [Resident #19] had withdrawn her allegation as well. The employee received a coaching regarding positive customer relations. The physician issued no new orders. Patient's daughter was fully satisfied with conduct of investigation and final outcome."	F 225		

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F 225	Continued From page 9 Further review of the facility's "Concern Form" dated 4/22/16 failed to evidence the initial allegation and the follow up to this incident was provided to OLC (office of licensure and certification) and DHP (Department of Health Professionals). On 8/10/16 at 4:30 p.m. an interview was conducted with ASM (administrative staff member) # 1, the administrator. When asked why the allegation of abuse by Resident # 19 was not reported to the Office of Licensure and Certification and the Department of Health Professionals ASM # 1 stated, "I didn't send it because the resident stated it (the incident) wasn't intentional." On 8/10/16 at 5:50 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings. No further information was provided by the end of the survey. References: (1) Common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 10 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 clinical record review, the facility staff failed to report three allegations of abuse to the state agency per the facility abuse policy for three of 20 Residents, Residents # 12, # 2, and # 19. 1. The facility staff failed to implement the facility policy to submit an initial and follow-up report to the state agency after an allegation of abuse by Resident # 12. 2. The facility staff failed to implement a policy to submit an initial and final report to the state agency in the required time frame after a reported allegation of abuse for Resident # 2. 3. The facility staff failed to implement a policy to submit an initial and final report to the state agencies, the Virginia Department of Health and the Department of Health Professionals in the required time frame after a reported allegation of abuse for Resident #19. The findings include: 1. The facility staff failed to implement the facility policy to submit an initial and follow-up report to the state agency after an allegation of abuse by Resident # 12.	F 226	**F226** It is the practice of the facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and the abuse of residents and misappropriation of resident property.	

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F 226	Continued From page 11 Resident # 12 was admitted to the facility on 5/12/15 and readmitted on 3/16/16 with diagnoses that included: osteoarthritis, peripheral neuropathy, diabetes, coronary artery disease and angina. Resident # 12's most recent MDS (minimum data set) assessment, an Annual Assessment, with an ARD (assessment reference date) of 5/22/16 coded Resident # 12 as understood by others and as able to understand others. Resident # 12 was coded on the BIMS (Brief Interview for Mental Status) with a score of 12 out of 15, indicating that the Resident is cognitively intact. During the survey process the FRIs (facility reported incidents) were requested. No FRIs were presented but instead "Concern Forms" were presented. A "Concern Form" for Resident # 12 was reviewed. The "Concern Form" for Resident # 12 documented that on 7/25/16 Resident # 12 went to (name of nurse) to remind her about a medication. Resident # 12 related that the nurse started yelling at her (Resident). Resident # 12 reported that the nurse was rude and insulting. During an interview on 8/10/16 at 4:50 p.m. with ASM (administrative staff member) # 1, the administrator, ASM # 1 stated, "I did not send any report to your office (state agency) because I finished the investigation and there was no need." During this interview the policy for reporting abuse and the meaning of "immediately" reporting to the state agency were discussed. At this time a request was made for any policy (state or facility) that the facility uses as a guideline. The following facility and state policies were	F 226	**I** **Corrective Action** A follow up visit has been completed by the Social Worker with the residents #12 and #2 for new or further concerns of mistreatment or abuse. No new concerns were noted. Resident #19 no longer resides in the facility. **II** **Identification** All residents residing in the facility have the potential to be affected by the alleged deficient practice.	

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F 226	Continued From page 12 presented by ASM # 1 on 8/10/16 at approximately 6:00 p.m. Review of the facility policy documented the following: "Patient Protection Practice Guide" under "Report/Respond ...Reporting. The center must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures (including to the state survey and certification agency)...The results of all investigations must to be reported to the administrator or his/her designated representative and to other officials in accordance with state law (including to the state survey and certification agency) with 5 (five) working days of the incident. CMS (Center for Medicare/Medicaid Services) defines "immediately" to mean as soon as possible, but not ought not to exceed 24 hours after discovery of the incident, in the absence of a shorter time frame requirement." Review of The Virginia Department of Health Office of Licensure and Certification policy "Reporting Abuse, Neglect, Misappropriation of Resident Personnel Property Or Facility Reported Incidents (FRI)" documented under, "General Rule. B. When incidences of staff misconduct occur, a federally certified facility is required to self-report those occurrences by filing an initial written report immediately to the OLC (Office of Licensure and Certification) and to any other state officials required by state law. e.g. the Adult Protective Services Unit of the Virginia Department of Social Services...NOTE: Facilities	F 226	**III** **Systematic Changes** The Administrator and other Department Heads would be re-educated by the Social Worker on the policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **IV** **Monitoring** The Administrator or designee will audit concerns of residents weekly for four weeks and	

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F 226	Continued From page 13 shall follow the reporting criteria of other agencies, such as APS/DSS (Adult Protective Services/ Department of Social Services) or DHP (Department of Health Professional), which may vary from this guideline." No further documentation was provided prior to exit. 2. The facility staff failed to implement a policy to submit an initial and final report to the state agency in the required time frame after a reported allegation of abuse for Resident # 2. Resident # 2 was admitted to the facility on 2/14/15 with diagnoses that included but were not limited to: deep venous thrombosis (1), hypertension (2), gastroesophageal reflux disease (3), urinary tract infection (4), diabetes mellitus (5), anxiety (6), depression, muscle weakness, obesity, pain, neurogenic bladder (7), and cerebral vascular accident (8). Resident # 2's most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/22/16, coded Resident # 2 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 2 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living. A review of the facility's "Investigation Report"	F 226	monthly for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **9/16/2016**	

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dated 6/16/16 documented, "Date of incident: 6/15/16. Summary of Alleged Incident: Patient, (Resident # 2) reported an allegation of unwanted sexual advances by OSM (other staff member) # 14, who works in housekeeping and laundry during evening hours. She cited buying of makeup gifts, unsolicited neck massage, uninvited kissing to her cheeks and lips."

The "Investigation Report" dated 6/17/16 documented, "Conclusion: After thorough investigation of this allegation, the IDT (interdisciplinary team) finds the resident to be credible, and given the fact that (OSM # 14) accepted that he had bought makeups for the resident as gift though they are not in any way related to each other, has sustained that resident's claim that (OSM # 14) made unwanted sexual advances towards (Resident # 2). However, given that the resident, in no way considered the action as abuse, but a concern to be handled through the facility's disciplinary process, no law enforcement agency is notified. In order to protect the resident and any other resident in the facility from such behaviors by (OSM # 14), therefore the IDT recommends the termination of (OSM # 14's) employment services in (Name of Facility) effective immediately. (OSM # 14) does not hold a license of any kind that would have warranted notification of such a board."

Further review of the facility's "Investigation Report" dated 6/16/16 and 6/17/16 failed to evidence the initial allegation and the follow up to this incident was provided to OLC (office of licensure and certification).

On 8/10/16 at 4:30 p.m. an interview was

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F 226	Continued From page 15 conducted with ASM (administrative staff member) # 1, the administrator. When asked why the allegation of abuse by Resident # 2 was not reported to the office of licensure and certification ASM # 1 stated, "I didn't send it because the employee was not licensed." On 8/10/16 at 5:50 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings. No further information was provided by the end of the survey. References: (1) A condition that occurs when a blood clot forms in a vein deep inside a part of the body. It mainly affects the large veins in the lower leg and thigh, but can occur in other deep veins such as in the arms and pelvis. This information was obtained from the website: <https://medlineplus.gov/ency/article/000156.htm>. (2) High blood pressure. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/highbloodpressure.html>. (3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) An infection in the urinary tract. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm>.	F 226		

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F 226	Continued From page 16 (5) A chronic disease in which the body cannot regulate the amount of sugar in the blood) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm>. (6) Fear. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/anxiety.html#summary>. (7) A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: <https://medlineplus.gov/ency/article/000754.htm>. (8) A stroke. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000726.htm. 3. The facility staff failed to implement a policy to submit an initial and final report to the state agencies, the Virginia Department of Health and the Department of Health Professionals in the required time frame after a reported allegation of abuse for Resident # 19. Resident # 19 was admitted to the facility on 3/21/16 with diagnoses that included but were not limited to: low iron, coronary artery disease (1), hypertension (2), hyponatremia (3), anxiety (4) and depression. Resident # 19's most recent MDS (minimum data	F 226		

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set), an admission assessment with an ARD (assessment reference date) of 3/28/16, coded Resident # 19 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 19 was coded as requiring extensive assistance of one staff member for activities of daily living.

A review of the facility's "Concern Form" dated 4/22/16 documented, "Documentation of Concern: Pt (Patient [Resident #19]) alleged inappropriate touching by staff CNA (certified nursing assistant) during transfer on 4/17/16."

The "Investigation Report" dated 4/22/16 documented, "Action Taken During Investigation: The male staff named in the allegation was suspended immediately while conducting the investigation. The patient's daughter and physician were notified. Patient withdrew the allegation; therefore, no state report was initiated." Under "Conclusion" it documented, "The allegation of inappropriate touching is unsubstantiated. The patient [Resident #19] had withdrawn her allegation as well. The employee received a coaching regarding positive customer relations. The physician issued no new orders. Patient's daughter was fully satisfied with conduct of investigation and final outcome."

Further review of the facility's "Concern Form" dated 4/22/16 failed to evidence the initial allegation and the follow up to this incident was provided to OLC (office of licensure and certification) and DHP (Department of Health Professionals).

On 8/10/16 at 4:30 p.m. an interview was

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F 226	Continued From page 18 conducted with ASM (administrative staff member) # 1, the administrator. When asked why the allegation of abuse by Resident # 19 was not reported to the Office of Licensure and Certification and the Department of Health Professionals ASM # 1 stated, "I didn't send it because the resident stated it (the incident) wasn't intentional." On 8/10/16 at 5:50 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings. No further information was provided by the end of the survey. References: (1) Common type of heart disease. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html>. (2) High blood pressure. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/highbloodpressure.html>. (3) Low sodium (salt) level. This information was obtained from the website: <https://medlineplus.gov/ency/article/000394.htm>. (4) Fear. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/anxiety.html#summary>.	F 226		
F 252	483.15(h)(1)	F 252		

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F 252 SS=D	Continued From page 19 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and clinical record review it was determined that the facility staff failed to maintain a resident's room in a clean manner for one of 20 residents in the survey sample, Residents # 6. A strong urine odor was noted in Resident # 6's room. The findings include: Resident # 6 was admitted to the facility on 5/12/15 and a readmitted on 7/11/16 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1), compression fractures (2), hypertension (3), dementia (4), benign prostatic hyperplasia (5), acute respiratory failure (6), depression disorder and vitamin D deficiency. Resident # 6's most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/18/16, coded Resident # 6 as scoring an 8 (eight) on the brief interview for mental status (BIMS) of a score of 0 - 15, 8 (eight) - being moderately impaired of cognition for making daily decisions. Resident # 6 was coded	F 252	**F252** This facility is in the practice of providing a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. **I** **Corrective Action** The room of resident #6 was immediately cleaned following awareness of the issue by the staff. The resident's beddings were changed. The floor was buffed and waxed. No odor was further noted.	

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F 252	Continued From page 20 as requiring extensive assistance to being totally dependent of one staff member for activities of daily living. Resident # 6 was coded as being "Occasionally incontinent" of bowel and "Frequently incontinent" of bladder. Observations of Resident # 6's room on 8/9/16 at 1:40 p.m., 3:10 p.m. and 3:35 p.m. revealed odors of urine. Further observations of Resident # 6's room revealed concentrated odors of urine emanating from Resident # 6's bed. Observations of the bed linens did not reveal them to be wet or stained. Resident # 6 was observed to be dry. Observations of Resident # 6's room were conducted with another state surveyor on 8/9/16 at 3:45 p.m. The other state surveyor confirmed odors of urine in Resident # 6's room. Further observations of Resident # 6's with the other state surveyor confirmed concentrated odors of urine emanating from Resident # 6's bed. On 8/9/16 at 3:50 p.m. an observation and interview was conducted with LPN (licensed practical nurse) # 2 in Resident # 6's room. When asked if Resident # 6's room smelled clean, LPN # 2 stated, "It doesn't smell good." When asked if the room and bed had an odor of urine, LPN # 2 stated, "I don't know how to answer your question." On 8/9/16 at 3:55 p.m. an observation and interview was conducted with CNA (certified nursing assistant) # 7 in Resident # 6's room. When asked if Resident # 6's room smelled clean, CNA # 7 stated, "The room doesn't smell clean." After smelling the Resident # 6's bed, CNA # 7 stated, "It does not smell up to par, not	F 252	**II** **Identification** All residents residing in the facility who are dependent for incontinent care have the potential to be affected by this alleged deficient practice. **III** **Systematic Changes** The Administrator or Designee will educate the Nursing Assistants and Housekeeping Staff on keeping resident's rooms and other parts of the facility clean and free of odor.	

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F 252	Continued From page 21 clean." When asked if she had taken care of Resident # 6, CNA # 7 stated, "I had (Resident # 6) on 7 to 3 (7:00 a.m. to 3:00 p.m.) shift. I changed the bed at 7:30 a.m." On 8/9/16 at 4:00 p.m. an observation and interview was conducted with ASM (administrative staff member) # 2, the director of nursing, in Resident # 6's room. When asked if Resident # 6's room and bed smelled clean, ASM # 2 stated, "It doesn't smell good." On 8/10/16 at 5:50 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings. No further information was provided by the end of the survey. References: (1) A disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/copd.html>. (2) Broken vertebrae. Vertebrae are the bones of the spine. This information was obtained from the website: <https://medlineplus.gov/ency/article/000443.htm>. (3) High blood pressure. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/highbloodpressure.html>. (4) A group of symptoms caused by disorders	F 252	**IV** **Monitoring** The Administrator of designee will make daily environmental rounds 5 times a week, including resident rooms to ensure cleanliness and an odor free environment for two weeks and weekly for four weeks. . Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **9/16/2016**	

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F 252	Continued From page 22 that affect the brain. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/dementia.html>. (5) An enlarged prostate. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html>. (6) A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.	F 252		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was	F 274	**F274** It is the practice of the facility to conduct a comprehensive assessment of a resident within 14 days. After the facility determines, or should have determined, that there has been a significant change in a resident's physical or mental condition.	

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F 274	Continued From page 23 determined that the facility staff failed to complete a significant change MDS assessment for 1 of 20 residents in the survey sample; Resident #5. For Resident #5, the 4/29/16 quarterly MDS assessment should have been a significant change MDS assessment. The findings include: Resident #5 was admitted on 6/16/15 with the diagnoses of but not limited to dementia, prostate cancer, psychosis, obstructive uropathy, dementia, depression, high blood pressure, thyroid cancer, and tube feeding. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/30/16. The resident was coded as severely cognitively impaired in ability to make daily life decisions, scoring a 4 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing and eating; extensive assistance for hygiene; limited assistance for transfers; supervision for ambulation; and was coded as incontinent of bowel and as having a catheter for bladder. A review of the January 28, 2016 significant change MDS, and the July 30 2016 quarterly MDS revealed multiple changes in the resident's status. Upon further review, it was revealed that these changes had occurred as of the April 29, 2016 quarterly MDS assessment, and therefore the April MDS assessment should have been completed as a significant change MDS.	F 274	**I** **Corrective Action** The quarterly MDS Assessment of 4-29-16 of Resident #5 has been modified to reflect a significant change (8/22/16). **II** **Identification** All the residents residing in the facility have the potential to be affected by this alleged deficient practice.	

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F 274	Continued From page 24 The changes identified are as follows: · BIMS; On January 30, 2016 was a 12; On April 29, 2016 was a 5. This was a significant decline. · Behavior; On January 30, 2016 1 area was marked; On April 29, 2016 3 areas were marked. This was a decline. · Bed mobility; On January 30, 2016 3/2 (required extensive assistance); On April 29, 2016 was a 2/3 (required limited assistance.) This was an improvement. · Transfer; On January 30, 2016 was a 3/2 (required extensive assistance); On April 29, 2016 was a 2/2 (required limited assistance.) This was an improvement. · Walk in room; On January 30, 2016 was a 3/2 (required extensive assistance); On April 29, 2016 was a 2/2 (required limited assistance.) This was an improvement. · Walk in corridor; On January 30, 2016 was a 3/2 (required extensive assistance); On April 29, 2016 was a 2/2 (required limited assistance.) This was an improvement. · Locomotion on unit; On January 30, 2016 was a 3/2 (required extensive assistance); On April 29, 2016 was a 2/2 (required limited assistance.) This was an improvement. · Locomotion off unit; On January 30, 2016 was a 3/2 (required extensive assistance); On April 29, 2016 was a 2/2 (required limited assistance.) This was an improvement. · Pressure Sores; On January 30, 2016 was an unhealed pressure sore; On April 29, 2016, there were no unhealed pressure sores. This was an improvement.	F 274	**III** **Systematic Changes** The Administrator or Designee will re-educate the MDS Coordinator and other interdisciplinary team members on determining a significant change assessment, to include significant resident improvement. **IV** **Monitoring** The Administrator or Designee will complete a weekly audit or completed MDS assessments for four weeks and monthly for two months for compliance of this requirement. . Data	

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F 274	Continued From page 25 On 8/10/16 at 4:03 p.m., RN #1, (Registered Nurse #1, the MDS nurse) stated that a significant change MDS was not done because there was no negative outcome. A review of the facility document, taken from the RAI manual (Resident Assessment Instrument) Version 3.0, October 2015, documented on page 2-22 to 2-24 documented, "Some Guidelines to Assist in Deciding if a Change is Significant or Not:.....Decline in two or more of the following: - Resident's decision-making changes; - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency, e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior).....Improvement in two or more of the following: - Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment;.....Overall improvement of resident's condition..." The RAI manual (Resident Assessment Instrument) Version 3.0, October 2015, also documents on page 2-23 the following: "A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement)." On 8/10/16 at 5:50 p.m., the Administrator and Director of Nursing, and the 2 unit managers (RN #2 and RN #3) were made aware of the findings.	F 274	collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **9/16/2016**	

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F 274	Continued From page 26 No further information was provided by the end of the survey.	F 274		
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 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, facility documented review and clinical record review, it was	F 278	**F 278** It is the practice of this facility to complete a complete and accurate Minimum Data Set (MDS) that accurately reflects the resident's status of our **residents.**	

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F 278	Continued From page 27 determined that that facility staff failed to complete an accurate MDS (minimum data set) assessment for three of 20 residents in the survey sample, Resident #7, Resident #6 and Resident #5. 1. Resident #7's five day admission MDS assessment with an ARD of 11/6/15, recorded a height of 65 inches for the resident. The quarterly MDS (minimum data set) assessment, with an ARD (assessment reference date) of 5/8/16 recorded a height of 63 inches. 2. Resident # 6's quarterly Minimum Data Set (MDS) assessment, with an ARD (assessment reference date) of 5/21/16, and the significant change MDS assessment, with an ARD of 7/18/16, did not accurately reflect the resident's height. 3. For Resident #5, the January 28, 2016 significant change MDS recorded a height of 58 inches for the resident. The April 29, 2016 quarterly, and the July 30, 2016 quarterly MDS assessments recorded the resident as 66 inches tall. The findings include: 1. Resident #7's five day admission MDS assessment with an ARD of 11/6/15, recorded a height of 65 inches for the resident. The quarterly MDS (minimum data set) assessment, with an ARD (assessment reference date) of 5/8/16 recorded a height of 63 inches. Resident #7 was admitted to the facility on 10/30/15 and readmitted on 11/18/15 with diagnoses that included but were not limited to:	F 278	I The MDS for residents #7, #6 and #5 have been corrected on 8/23/2016 to accurately reflect the status of the residents.	

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F 278	Continued From page 28 high blood pressure, chronic obstructive lung disease, difficulty walking, anxiety and fractured hip. The resident's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/8/16 coded the resident having a nine out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively to make daily decisions. The resident was coded as requiring the assistance from staff for all activities of daily living. The resident was coded in Section K of the MDS as being 63 inches in height. Review of Resident #7's five day admission MDS assessment with an ARD of 11/6/15 coded the resident in Section K of the MDS as being 65 inches in height. This was a two inch height difference from the height coded on the quarterly MDS assessment with an ARD of 5/8/16 (a period of six months). An interview was conducted on 8/10/16 at 1:50 p.m. with OSM (other staff member) #6, the registered dietitian. When asked who completed Section K of the MDS, OSM #6 stated she did. When asked how Resident's heights were entered, OSM #6 stated, "I don't measure them myself. The heights are entered from (name of software) from the nursing staff and it is auto populated into the MDS." When asked the importance of having a correct height documented, OSM #6 stated, "For their energy needs it would be ideal to have the best height and weight." When asked what policy staff used for completing the MDS assessments, OSM #6 stated, "The RAI (resident assessment interview)."	F 278	II Residents residing in the facility who require a MDS assessment have the potential to be affected by this alleged deficient practice. Residents MDS were audited to ensure accuracy of information submitted. Any errors found were corrected and MDS submitted.	

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F 278	Continued From page 29 An interview was conducted on 8/10/16 at 1:53 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked how staff measured a resident's height, ASM #2 stated that they usually measure the height when the resident was lying down. When asked which height was correct for Resident #7, ASM #2 stated, "I can't answer that." When asked if either one of the MDS assessments for Resident #7 were correct, ASM #2 stated, "There are times that there are inaccuracies." When asked if that was acceptable, ASM #2 stated, "Definitely not." ASM #2 stated, "When I took it (Resident #7's height) it was 61.5 inches, I took it twice and got 61.5 inches." Review of the CMS's (Centers for Medicare and Medicaid) RAI version 3.0 documented, "K0200: Height and Weight. Item Rationale. Health-related Quality of Life. Diminished nutritional and hydration status can lead to debility that can adversely affect health and safety as well as quality of life. Planning for Care. Height and weight measurements assist staff with assessing the resident's nutrition and hydration status by providing a mechanism for monitoring stability of weight over a period of time....." Review of the facility's policy titled, "HEIGHT MEASUREMENT GUIDE. PURPOSE. Stature or height is a necessary parameter for determining energy requirements and assessing desirable weight ranges." No further information was obtained prior to exit.	F 278	**III** Staffs responsible for the completion of the MDS will be educated to follow the RAI manual guidelines when coding the MDS. The MDS Coordinator will audit MDS weekly and before submissions for the next 90 days to ensure proper coding has been entered. **IV** The Administrator or Designee will review the results of the audits. Data collected will be	

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F 278	Continued From page 30 2. Resident # 6's quarterly Minimum Data Set (MDS) assessment, with an ARD (assessment reference date) of 5/21/16, and the significant change MDS assessment, with an ARD of 7/18/16, did not accurately reflect the resident's height. Resident # 6 was admitted to the facility on 5/12/15 and readmitted on 7/11/16 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1), compression fractures (2), hypertension (3), dementia (4), benign prostatic hyperplasia (5), acute respiratory failure (6), depression disorder and vitamin D deficiency. Resident # 6's most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/18/16, coded Resident # 6 as scoring an 8 (eight) on the brief interview for mental status (BIMS) of a score of 0 - 15, 8 (eight) - being moderately impaired of cognition for making daily decisions. Resident # 6 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living. Review of Section K0200 "Height and Weight" coded Resident # 6's height as 54 inches. Review of the most recent quarterly MDS assessment with an ARD of 5/21/16 coded Resident # 6 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11- being moderately impaired in cognition for making daily decisions. Review of Section K0200 "Height and Weight" coded Resident # 6's height as 60 inches.	F 278	forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. V Date of compliance is September 16, 2016	

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F 278	Continued From page 31 On 8/10/16 at 1:45 p.m., in an interview was conducted with OSM (other staff member) # 6, registered dietician, and ASM (administrative staff member) # 2, director of nursing. When asked about the process for obtaining a resident's height, OSM # 6 stated, "It's entered into PCC (Point Click Care, an electronic record system) by nursing and auto (automatically) populated into the MDS." When asked about the height discrepancies on Resident # 6's significant change assessment with an ARD of 7/18/16 and the quarterly MDS assessment with and ARD of 5/21/16, ASM # 2 stated, "I can't speak to the discrepancy. I'll look into it and get the correct height." On 8/10/16 at 3:05 p.m. an interview was conducted with ASM # 2, the director of nursing. ASM # 2 stated the Resident # 6 was re-measured by an aide, the unit manager and herself revealing a height of 58 inches. When asked which of Resident # 6's heights were correct ASM # 2 stated, "They're all correct. The height is based on the resident's status at the time he was measured." ASM # 2 was then asked to provide evidence that the three heights of 54, 60 and 58 inches were correct and to provide evidence of Resident # 6's change in status for each of the heights. ASM # 2 was unable to provide any supportive documentation. On 8/10/16 at 4:00 p.m. an interview was conducted with RN (registered nurse) # 1, MDS coordinator. When asked about the height discrepancies on Resident # 6's significant change assessment with an ARD of 7/18/16 and the quarterly MDS assessment with and ARD of 5/21/16 RN # 1 stated, "It's really hard. I don't know." When asked what policy they follow for	F 278		

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F 278	Continued From page 32 completing the MDS, RN # 1 stated, "We follow the RAI (resident assessment instrument) manual." The RAI (Resident Assessment Instrument) manual documented, "Steps for Assessment for K0200A, Height 1. Base height on the most recent height since the most recent admission/entry or reentry. Measure and record height in inches. 2. Measure height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (shoes off, etc.). 3. For subsequent assessments, check the medical record. If the last height recorded was more than one year ago, measure and record the resident's height again." On 8/10/16 at 5:50 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings. No further information was provided by the end of the survey. References: (1) A disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/copd.html>. (2) Broken vertebrae. Vertebrae are the bones of the spine. This information was obtained from the website: <https://medlineplus.gov/ency/article/000443.htm>.	F 278		

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F 278	Continued From page 33 (3) High blood pressure. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/highbloodpressure.html>. (4) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/dementia.html>. (5) An enlarged prostate. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html>. (6) A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 3. For Resident #5, the January 28, 2016 significant change MDS recorded a height of 58 inches for the resident. The April 29, 2016 quarterly, and the July 30, 2016 quarterly MDS assessments recorded the resident as 66 inches tall. Resident #5 was admitted on 6/16/15 with the diagnoses of but not limited to dementia, prostate cancer, psychosis, obstructive uropathy, dementia, depression, high blood pressure, thyroid cancer, and tube feeding. The most recent MDS (Minimum Data Set) was a	F 278		

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F 278	Continued From page 34 quarterly assessment with an ARD (Assessment Reference Date) of 7/30/16. The resident was coded as severely cognitively impaired in ability to make daily life decisions, scoring a 4 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing and eating; extensive assistance for hygiene; limited assistance for transfers; supervision for ambulation; and was incontinent of bowel and had a catheter for bladder. A review of the January 28, 2016 significant change MDS assessment, and the July 30 2016 quarterly MDS assessment revealed a discrepancy in the resident's height. In addition the April 29, 2016 quarterly MDS assessment was reviewed. The January 28, 2016 significant change MDS recorded a height of 58 inches for the resident. The April 29, 2016 quarterly and the July 30, 2016 quarterly MDS assessments, recorded the resident as 66 inches tall. On 8/10/16 at 4:03 p.m., RN #1, (Registered Nurse #1, the MDS nurse) stated that she didn't know what happened. On 8/10/16 at 5:50 p.m., the Administrator and Director of Nursing, and the 2 unit managers (RN #2 and RN #3) were made aware of the findings. No further information was provided by the end of the survey.	F 278		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		

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F 309	Continued From page 35 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility failed to maintain the highest level of wellness for one of twenty residents in the survey sample, Resident #7. Facility staff failed to review Resident #7's right shoulder x-ray on 11/13/15 which showed a impacted humeral (upper arm bone) neck fracture resulting in a three day delay in providing the resident treatment causing a decline in the fracture. The findings include: Resident #7 was admitted to the facility on 10/30/15 and readmitted on 11/18/15 with diagnoses that included but were not limited to: high blood pressure, chronic obstructive lung disease, difficulty walking, anxiety and fractured hip. The resident's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/8/16 coded the resident having a nine out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively to make daily decisions. The resident was coded as requiring the assistance from staff for all activities of daily living.	F 309	Past noncompliance: no plan of correction required.	

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Review of the care plan created on 10/30/15 and revised on 5/30/16 documented, "Focus. At risk for falls due to impaired balance/poor coordination...Interventions. Call light within reach with rapid response. Encourage/Assist to turn and reposition per resident's needs. Have commonly used articles within easy reach, low bed."

Review of the fall assessment dated 10/30/15 at 2:20 p.m. documented in part, "Physical Performance Limitations. 4. Impaired balance during transitions. Disease & Conditions. 11. Decline in functional status. 20. Chronic or acute condition resulting in instability. 31. Impulsivity or poor safety awareness. No falls at this time fall precaution in place."

Review of the occupational therapy notes dated 11/12/15 documented in part, "Stand from bed for repositioning, max (maximum) A (assistance)."

Review of the nurse's notes dated 11/13/15 at 12:27 p.m. documented, "Extensive assistance with ADLS (activities of daily living) and transfers."

Review of the facility's document titled, "STATEMENT" from LPN (licensed practical nurse) #7, the nurse caring for the resident, documented, "I was informed by the other nurse that this patient fell but has been assisted back to bed. So I asked the supervisor to assist me to assess this patient upon arrival to patient room she started (sic) c/o (complain /of) severe pain to R (right) shoulder. X-Ray to R shoulder ordered stat (Immediate)."

Review of Resident #7's 11/13/15 right shoulder x-ray report documented, "Examination: SHOULDER COMPLETE...Conclusion: Acute or

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MANORCARE HEALTH SERVICES-ALEXANDRIA	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(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 309	Continued From page 37 subacute mildly impacted humeral neck fracture." The report was faxed to the facility on 11/13/15 at 7:46 p.m. Review of the nurse's notes dated 11/14/15 at 2:28 a.m. Res (resident) is (sic) sitting at the foot of the bed in front of her w/c (wheelchair) when asked (sic) she said she was trying to transfer herself from w/c and lost her balance and fell on her R (right) shoulder Head to toe assessment was done no apparent injury noted at this time Res c/o pain on (sic) shoulder Percocet (a narcotic pain medication (1)) 1 tab (tablet) was giving (sic) an order received for R shoulder x-ray." Review of the physician's notes did not evidence documentation regarding the x-ray results. Review of the nurse's notes dated 11/14/15 at 8:12 p.m. documented, "Right shoulder noted large bruise/edema (swelling) s/p (status post) fall yesterday. Medicated with Percocet 1 tab po (by mouth) X (times) 1 for 7/10 (0 is no pain and ten is the worst pain) pain level with relief. Ice applied PRN (as needed). Safety/fall precautions maintained." Review of the nurse's notes dated 11/15/15 at 9:30 p.m. documented, "Right shoulder remains bruised/edema. No fx (fracture) per result of X ray. Safety/fall precautions maintained. Review of the occupational therapy notes dated 11/16/15 documented, "R (right) UE (upper extremity) swelling and bruising noted. Pt (patient) c/o (complained of) pain. ROM (range of motion) of elbow attempted. RN (registered nurse) notified, requested x-ray. Pt has fx	F 309		

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F 309	Continued From page 38 (fracture), being sent out to hospital." Review of Resident #7's right shoulder x-ray dated, 11/16/15 documented, "Results: Compared to the examination 11/13/2015 the previously noted fracture, has changed position. There is no evidence of healing. Conclusion: Fractures change position into a less favorable relationship." Review of the emergency room record dated 11/16/15 at 2:04 p.m. documented in part, "96 y.o. (years old) female h/o (history of) dementia currently in rehab (rehabilitation) brought from rehab s/p (status post) fall 3 days ago. Per family, pt (patient) was trying to get out of wheelchair but fell. Patient currently has right arm ecchymosis and severe pain when moving right arm....4. Severity (of pain): moderate, 5. Timing: constant. 6. Activities that worsen symptoms: moving. 11. Are symptoms worsening? yes." Review of the orthopedic doctor's note dated 11/16/15 documented, "Plan: Discussed with patient and family. Non operative management. Right upper extremity will be placed in a sling." Review of the facility's document titled, "STATEMENT" from OSM (other staff member) # 14, receptionist, documented in part, "Between 500-530 (5:00 p.m. to 5:30 p.m.) (name of resident) daughter called and said that she was talking to her mother on the phone and she said she needed help because she fell and she thinks she may have broken her shoulder....I spoke with (RN [registered nurse] #5, the nursing supervisor) and told her what the daughter said." Review of the facility's document titled,	F 309		

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F 309	Continued From page 39 "STATEMENT" by RN #5 dated 11/17/15 documented, "Did you work with (name of resident) on 11/13/15 at 3-11 (3:00 p.m. to 11:00 p.m.) shifts (sic)? NO. How did you come involved in her care? I was the supervisor and nurse taking care of her called me to help her assess her, when went there she was complaining of pain to right shoulder. I immediately called the doctor and I called for stat X-ray while awaiting a call back from the doctor....What is the process when you call in a STAT x-ray? You place a call in for order, they give you a claim number and then you wait for a fax confirmation we placed in the chart. What do you do to follow up? You wait for them to call you regardless of the results and then you to look into the fax. Did you call before you left to (name of x-ray company) to follow up with result? I didn't call to follow up because.....Did you give report to incoming nurse? Yes I told her that the result of the x-ray was pending. The following day when I came in around 3pm (LPN #6) told me the result was negative. Then I assessed the patient she looked worse than she did on Friday..." Review of the facility's document titled, "STATEMENT" by RN #4 dated 11/18/15 documented, "On Friday 11/13/15 when you arrived on your 11-7 (11:00 p.m. to 7:00 a.m.) shift who gave you report about the unit? When I arrived, after I made my rounds I took report from (RN #5) who was the supervisor that evening, she proceeded to tell me that (name of resident) fell and she has sustained an injury to her right should, they have been (sic) medicated her for pain and an X-ray was ordered and the results were negative for any broken bones. Did you see the actual x-ray results? NO. did you call to follow up about the X-ray results with (name of x-ray	F 309		

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F 309	Continued From page 40 company)? NO." Review of the facility's document titled, "STATEMENT" by RN #2, the unit manager, not dated documented, "She (RN #5) told me she (Resident #7) had fallen trying to transfer. She told me an x-ray was done and was negative according to her. However she said the Pt. was c/o pain and their (sic) were swelling on that shoulder...The family wanted her to be seen by the doctor." An interview was conducted on 8/10/16 at 5:10 p.m. with RN #5, the nursing supervisor. When asked about the events related to Resident #7's fall on 11/13/15, RN #5 stated, "I was supervisor that night, I had two nurses and we had three admissions and they take a lot of work. The nurse assigned to her was new and I was trying to help her. So, we were told that the patient had fallen so we went there (to the resident's room). She (LPN #7, the nurse caring for the resident) didn't know what to do so I went there, I assessed the patient. I got the order after I called the doctor. I called x-ray so they came and it was done. I was waiting for them to call me if there was a fracture before they would fax it." When asked if she had checked the fax machine for the shoulder x-ray results, RN #5 stated, "There was a lot of admissions, I was doing a lot of stuff. I wrote the report at the end of the shift and told them to follow up (on the x-ray) because we didn't get the report. The next day in the afternoon I asked the nurse if we got the x-ray, she said there was no fracture, so I charted that there was no fracture. But I should have seen the results so I took her word." An interview was conducted on 8/10/16 at 5:20	F 309		

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F 309	Continued From page 41 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked about the events related to Resident #7's fall on 11/13/15 (a Friday), ASM #2 stated, "On Monday I looked at her shoulder and said it didn't look right." When asked who was responsible to check a stat x-ray result, ASM #2 stated, "The nurse caring for the resident, all of us." On 8/11/16 at 9:10 a.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern for harm due to staff failing to follow up on Resident #7's shoulder x-ray on 11/13/15 which created a delay in treatment and a decline in the fracture. ASM #1 and ASM #2 were made aware of the complaint allegations at that time. An attempt to contact LPN #7, the nurse who cared for Resident #7 on 11/13/15, was made on 8/11/16 at 9:28 a.m. A message was left for LPN #7 to call the facility. The LPN did not return the call. An interview was conducted on 8/11/16 at 10:10 a.m. with LPN (licensed practical nurse) #3. When asked what staff did in regards to a physician's order for a stat x-ray, LPN #3 stated, "When stat, says it all, it means now. When get results work on it right away and call the doctor." When asked if there was any time stat x-ray results were not followed up on, LPN #3 stated, "No." An interview was conducted on 8/11/16 at 10:15 a.m. with LPN #4. When asked the process staff followed in regards to a physician's order for a stat x-ray, LPN #4 stated, "Means I have to have to do it right away, call the radiology company for	F 309		

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F 309	Continued From page 42 stat, call the family and let them know we are going to do it stat." When asked how staff followed up in regards to getting the x-ray results, LPN #4 stated, "If I have a stat order I always check (the fax machine) frequently and sometimes I even call (the x-ray company)." A telephone interview was conducted on 8/11/16 at 10:59 a.m. with LPN #6, the nurse who assisted Resident #17 to bed after the fall. When asked what she recalled about the fall Resident #7 sustained on 11/13/15, LPN #6 stated, "I remember I wasn't her nurse. I went to help her and get the patient to bed. We got an x-ray which was a problem.....I remember, honestly, oh boy, the nurse who had the patient, I don't know if she got the results right away. Follow up was rough; we didn't get a clear picture of what was going on." When asked what process staff followed when a stat x-ray was done, LPN #6 stated, you ' re supposed to check on the x-ray before you leave the building. I remember that day was busy all over." An interview was conducted on 8/11/16 at 11:35 a.m. with ASM #1 and ASM #2. ASM #2 stated, "When I found out about the issue, I initiated a PIP (performance improvement plan). My priority was patient comfort." When asked what they determined from the investigation, ASM #2 stated, "We did not follow our policy in following up on an x-ray in a timely manner. I was concerned about delay in treatment. I discussed it with the supervisor and the actual nurse that took care of the patient and did immediate education. We have a plan of correction in place to follow up (on diagnostic tests). We have asked the (x-ray) company to notify the DON (director of nursing) and the administrator of all positive results. We	F 309		

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F 309	Continued From page 43 have the (x-ray) results now come to (name of software) directly so when the nurse opens up the computer it is right there." Review of the facility's plan of correction documented, "Identified Patient(s): (Name of resident [Resident #7]) fell on 11/13/15, X-ray ordered stat. Results received but MD (medical doctor) was not notified. Like Patients: Current patients in house have the potential to be affected. Diagnostic records of all patients in house have been audited from Nov. 13 2015 until current. System Correction: All LPN/RN will be re-educated in lab (laboratory) tracking process/Guidelines. Staff discipline per facility protocol. Copies of daily Diagnostic results will be brought to the morning QA (quality assurance) meeting to ensure appropriate document has been made. Monitoring: DCDs (department care directors) will do random audits daily and monthly for 2 months to ensure diagnostics results are and documentation has been placed in chart. Resolution Date: 1/15/16. QAPI (quality assurance performance improvement) Committee: Identified concerns will be brought to the facility QA committee for further recommendations and revisions to the plan of correction." A review of the facility's laboratory and diagnostic education to the nurses was dated 11/20/15. Review of the facility's laboratory and diagnostic tracking forms revealed complete documentation of the residents' testing and results. Review of the facilities titled, "REQUIREMENTS AND GUIDELINES FOR CLINICAL RECORD	F 309		

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F 309	Continued From page 44 CONTENT" documented, "Labs and Special Reports. The findings for each lab or special test ordered are retained in the patient's clinical record. When a lab or test result is received, a nurse reviews the results, notes the findings, initials and dates the report, contacts the physician as clinically indicated or as requested by the physician and enters a progress note." During the survey current residents were reviewed and no concerns were identified. No further information was provided prior to exit. In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. Past non compliance COMPLAINT DEFICIENCY (1) PERCOCET is indicated for the management of moderate to moderately severe pain, severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from the website: <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4dd36cf5-8f73-404a-8b1d-3bd53bd90c25>	F 309		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 45 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide nail care for one of 20 residents in the survey sample, Resident # 6 Facility staff failed to maintain Resident # 6's finger nails in a clean and neat manner. The findings include: Resident # 6 was admitted to the facility on 5/12/15 and readmitted on 7/11/16 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1), compression fractures (2), hypertension (3), dementia (4), benign prostatic hyperplasia (5), acute respiratory failure (6), depression disorder and vitamin D deficiency. Resident # 6's most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/18/16, coded Resident # 6 as scoring an 8 (eight) on the brief interview for mental status (BIMS) of a score of 0 - 15, 8 (eight) - being moderately impaired of cognition for making daily decisions. Resident # 6 was coded	F 312	**F312** It is the practice of this facility to carry out activities of daily living for a resident who is dependent for care to receive the necessary services to maintain good nutrition, grooming, and personal and oral care. **I** **Corrective Action** The fingernails of Resident #6 have been clipped, cleaned, and	

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F 312	Continued From page 46 as requiring extensive assistance to being totally dependent of one staff member for activities of daily living. Resident # 6 was coded as being "Occasionally incontinent" of bowel and "Frequently incontinent" of bladder. On 8/9/16 at 1:40 p.m. an observation of Resident # 6 revealed he was lying in bed awake. Further observation of Resident # 6's finger nails on his right and left hands revealed black and brown substances under all his finger nails and all the nails were chipped, cracked and extended beyond the ends of the fingers. On 8/10/16 at 4:00 p.m. an observation of Resident # 6 revealed he was lying in bed awake. Further observation of Resident # 6's finger nails on his right and left hands revealed black and brown substances under all his finger nails and all the nails were chipped, cracked and extended beyond the ends of the fingers. On 8/10/16 at 4:15 p.m. an observation of Resident # 6's finger nails was conducted with CNA (certified nursing assistant) # 9. After examining Resident # 6's finger nails CNA # 9 agreed that Resident #6's nails were long, dirty and in need of care. On 8/10/16 at 4:20 p.m. an observation of Resident # 6's finger nails was conducted with LPN (licensed practical nurse) # 2. After examining Resident # 6's finger nails, LPN # 2 agreed that Resident #6's finger nails were long, dirty and in need of care. LPN # 2 further stated, "He's noncompliant." When asked were Resident # 6's noncompliance with nail care would be documented, LPN # 2 stated, "Would be documented in the progress notes." When asked	F 312	now remain neat. Other residents' fingernails were also maintained in a neat manner. **II** **Identification** All residents residing in the facility who require dependent care have the potential to be affected by the alleged deficient practice.	

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F 312	Continued From page 47 about nail care for Resident # 6, LPN # 2 stated, "Finger nails are cut when they are long and cleaned every day. Sometimes staff will clean and cut his nails. I don't know the last time his nails were cleaned and cut." The care plan for Resident # 6 dated 6/15/2016 documented, "Focus: Resistive/noncompliant with treatment/care refuses showers, refuses to have room cleaned, throws paper towels on the floor in toilet room r/t (related to): dementia." Under "Intervention" it documented, "Allow for flexibility in ADL (activities of daily living) routine to accommodate mood, preferences and customary routine; Elicit family input for best approaches; ask physician to explain/reinforce need for treatment; If resists care, leave (if safe to do so) and return later." The "Progress Notes" for Resident # 6 dated 5/12/15 through 8/5/16 failed to evidence documentation of Resident # 6's refusal of finger nail care. On 8/11/16 at 9:05 a.m. an interview was conducted with CNA (certified nursing assistant) # 6 regarding cleaning and cutting finger nails for residents'. CNA # 6 stated, "CNAs do it if the resident isn't a diabetic. It's done as needed. Hands are examined during A.M. (morning) care and if needed it is done during care. If the resident refuses, try to explain the reason for care and if they stall refuses I notify the nurse and try again later." On 8/11/16 at 9:20 a.m. an interview was conducted with RN (registered nurse) # 4 regarding cleaning and cutting finger nails for residents'. RN # 4 stated, "CNAs do it during	F 312	**III** **Systematic Changes** The Administrator or Designee will re-educate staff on maintaining residents' fingernails in a clean and neat manner. **IV** **Monitoring** The Director of Nursing (DON) or Designee will audit nail care of residents weekly for 4 weeks and monthly for 2 months. The Administrator will do a random spot check for an additional one	

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F 312	Continued From page 48 daily care. It's their responsibility to check the resident daily during care and it's the responsibility of all shifts. If the resident refuses I try to explain the importance and reason for nail care. If the resident still refuses I document it in the nurse's notes and notify the physician and responsible party." On 8/11/16 at 9:30 a.m. an interview was conducted with CNA # 1 regarding cleaning and cutting of finger nails for residents'. CNA # 1 stated, "CNAs are responsible. It's done when needed." When asked how it's determined that a resident's finger nails need to be cut and cleaned, CNA # 1 stated, "Check them every day during daily care. If they refuse I tell the nurse." On 8/11/16 at 9:45 a.m. an interview was conducted with LPN # 5 regarding cleaning and cutting finger nail for residents. LPN # 6 stated, "CNAs clean and cut finger nails during care every day." On 8/11/16 at 10:15 a.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing regarding cleaning and cutting finger nails for residents'. ASM # 2 stated, "It's the responsibility of aides and nurses. It's done during daily care on a daily basis. If they refuse try attempting again, if they continue to refuse respect their wishes." When asked if the resident's refusal of care would be documented, ASM # 2 stated, "It wouldn't be documented." When asked why a resident's refusal would not be documented, ASM # 2 stated, "It would be a best practice but it is not required." When asked about Resident # 6's finger nails not being cut and cleaned ASM # 2 stated, "It should have been done but we don't	F 312	week for compliance. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **9/16/2016**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 49 know if he refused because it's not a requirement to document refusal of nail care." The facility's policy "Nail Care" documented, "Purpose: To provide for personal hygiene needs and prevent infection." On 8/10/16 at 5:50 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings. No further information was provided prior to exit. Fundamentals of Nursing, 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 863, documents, "Providing hygiene is a very basic part of a client's care. Caring practices help to alleviate the client's anxiety and promote comfort and relaxation while performing each hygiene measure." References: (1) A disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/copd.html>. (2) Broken vertebrae. Vertebrae are the bones of the spine. This information was obtained from the website: <https://medlineplus.gov/ency/article/000443.htm>. (3) High blood pressure. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/highbloodp	F 312		

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	495011	A. BUILDING _____ B. WING _____	C 08/11/2016

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F 312	Continued From page 50 ressure.html>. (4) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/dementia.html>. (5) An enlarged prostate. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html>. (6) A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.	F 312		
F 315 SS=D	COMPLAINT DEFICIENCY 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 315	**F315** It is the practice of this facility to ensure that a resident who enters the facility without a indwelling catheter is not catheterized unless the residents clinical condition demonstrated that need; and a resident who is	

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F 315	Continued From page 51 document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to provide Foley care in a manner to prevent infection for one of 20 residents in the survey sample, Resident #4. Facility staff failed to keep Resident #4's Foley bag and tubing off the floor. The findings include: Resident #4 was admitted to the facility on 9/9/15 and readmitted on 11/7/15 with diagnoses that included but were not limited to: dementia, muscle weakness, high blood pressure, arthritis and elevated cholesterol. The most recent MDS (minimum data set), a quarterly assessment, with an assessment reference date of 6/6/16 coded the resident as being severely impaired cognitively to make daily decisions. The resident was coded requiring staff assistance for all activities of daily living. The resident was coded as having a urinary catheter. An observation of Resident #4 was made on 8/10/16 at 9:30 a.m. The resident was lying in bed on her right side with her eyes closed. The Foley bag was on the left side of the bed. The Foley bag was in a privacy bag, the bag and approximately ten inches of the Foley tubing were lying directly on the floor. An observation of Resident #4 was made on 8/10/16 at 11:20 a.m. The resident was lying in the bed on her right side with a long pillow propped behind her back. The Foley bag and approximately eight inches of the tubing were	F 315	incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. **I** **Corrective Action** The Foley catheter tubing and bag of resident #4 was immediately removed from touching the floor. Upon the staff being aware of the issue, all other residents with foley catheters in the facility were audited immediately for correction of the alleged deficient practice. **I** **Identification** All the residents who reside in the facility that have indwelling	

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F 315	Continued From page 52 lying directly on the floor. An observation was made on 8/10/16 at 11:22 a.m. with LPN (licensed practical nurse) #4, the nurse caring for the resident. When asked to check the Foley bag, LPN #4 raised the height of the bed to get the Foley bag and tubing off the floor. When asked what she had seen, LPN #4 stated, "The Foley was in the privacy bag and the bed was low so it was on the floor. When asked if there was tubing on the floor LPN #4 stated, "A little bit was dangling there, um hum." When asked if it was acceptable for the Foley bag and tubing to be directly on the floor, LPN #4 stated, "No, it's an infection issue." When asked if she had checked the Foley bag that day, LPN #4 stated, "I checked it at the beginning of my shift." LPN #4 stated that the resident usually had a private caregiver but she was going to be in later so, she (LPN #4) had been checking on Resident #4 every 45 minutes or so. Review of the physician's orders dated on signed on 7/21/16 documented, "09/10/15: INDWELLING FOLEY CATHETER #16F (french)/10ML (milliliters) STRAIGHT TO GRAVITY DRAINAGE...." Review of the August 2016 MAR, medication administration record, documented, INDWELLING FOLEY CATHETER #16F/10ML STRAIGHT TO GRAVITY DRAINAGE...." Review of Resident #4's care plan created on 9/10/15 and revised on 7/18/16 documented in part, "Use of indwelling urinary catheter....Report to physician signs of UTI (urinary tract infection) such as blood, cloudy urine, fever, increased restlessness, lethargy, c/o (complaints of)	F 315	Foley catheters have the potential to be affected by this alleged deficient practice (8/10/16). **III** **Systematic Changes** The DON or Designee will re-educate the clinical staff on the proper handling of Foley catheters, to include resting on the floor. Other non-clinical staff members will also be educated to reinforce the observation and reporting of potential noncompliance of the alleged deficient practice. **IV** **Monitoring** The DON or Designee will audit Foley catheter handling	

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F 315	Continued From page 53 pain/burning." An interview was conducted on 8/10/16 at 5:05 p.m. with RN (registered nurse) #3, the unit manager. When asked if it was acceptable for a Foley bag and tubing to be lying on the floor, RN #3 stated, "It's an infection control thing, nothing should be touching the floor. I would have changed the whole thing (bag and tubing)." RN #3 was made aware of the findings. An interview was conducted on 8/11/16 at 11:40 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked if it was acceptable for a Foley bag and tubing to be lying on the floor, ASM #2 stated, "It's an infection control issue." ASM #1, the administrator and ASM #2 were made aware of the findings at that time. Review of the facility's policy did not reveal additional information. No further information was provided prior to exit.	F 315	weekly for 4 weeks and monthly for 2 months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **9/16/2016**	
F 328 SS=D	COMPLAINT DEFICIENCY 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care;	F 328		

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F 328	Continued From page 54 Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide podiatry services for one of 20 residents in the survey sample, Resident # 6 Facility staff failed to maintain Resident # 6's toe nails in a clean and neat manner. The findings include: Resident # 6 was admitted to the facility on 5/12/15 and readmitted on 7/11/16 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1), compression fractures (2), hypertension (3), dementia (4), benign prostatic hyperplasia (5), acute respiratory failure (6), depression disorder and vitamin D deficiency. Resident # 6's most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/18/16, coded Resident # 6 as scoring an 8 (eight) on the brief interview for mental status (BIMS) of a score of 0 - 15, 8 (eight) - being moderately impaired of cognition for making daily decisions. Resident # 6 was coded as requiring extensive assistance to being totally dependent of one staff member for activities of daily living. On 8/9/16 at 1:40 p.m. an observation of	F 328	**F328** It is the practice of this facility to ensure that residents receive proper treatment and care for the following special services: Injections, parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prosthesis.	

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F 328	Continued From page 55 Resident # 6 revealed he was lying in bed awake. Further observation of Resident # 6's feet revealed the second, third and fourth toe nails on the right and left feet were approximately a quarter inch past the end of each toe. On 8/10/16 at 4:00 p.m. an observation of Resident # 6 revealed he was lying in bed awake. Further observation of Resident # 6's feet revealed the second, third and fourth toe nails on the right and left feet were approximately a quarter inch past the end of each toe. On 8/10/16 at 4:15 p.m. an observation of Resident # 6's toe nails was conducted with CNA (certified nursing assistant) # 9. After examining Resident # 6's toe nails, CNA # 9 agreed that Resident #6's toe nails were long and in need of being trimmed. On 8/10/16 at 4:20 p.m. an observation of Resident # 6's toe nails was conducted with LPN (licensed practical nurse) # 2. After examining Resident # 6's toe nails, LPN # 2 agreed that Resident #6's toe nails were long and in need of trimming. LPN # 2 further stated, "He's noncompliant." When asked where Resident # 6's noncompliance with toe nail care would be documented LPN # 2 stated, "Would be documented in the progress notes." When asked about toe nail care for Resident # 6, LPN # 2 stated, "Nails are cut when they are long. I don't know the last time his toenails were cut." The care plan for Resident # 6 dated 6/15/2016 documented, "Focus: Resistive/noncompliant with treatment/care refuses showers, refuses to have room cleaned, throws paper towels on the floor in toilet room r/t (related to): dementia." Under	F 328	**I** **Corrective Action** The toenails of resident #6 have been cleaned and neatly maintained on the day the alleged deficient practice was notified to the facility. All other residents' toenails have also been audited and treated as necessary. **II** **Identification** All the residents residing in the facility have the potential to be	

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F 328	Continued From page 56 "Interventions" it documented, "Allow for flexibility in ADL (activities of daily living) routine to accommodate mood, preferences and customary routine; Elicit family input for best approaches; ask physician to explain/reinforce need for treatment; If resists care, leave (if safe to do so) and return later." Review of Resident # 6's clinical record revealed a "Podiatric Services Report" dated "05/17/2016." Further review of the "Podiatric Services Report" revealed Resident # 6 received podiatry service on 5/17/16. It documented, "Debrided (removed) symptomatic. Dystrophic (affected). Inncurvated (ingrown) nails. The "Progress Notes" for Resident # 6 dated "05/17/2016" documented, " Resident was seen by the Podiatrist today, please see chart for Podiatrist ' s notes/orders. Resident remains stable, no distress noted. " On 8/11/16 facility staff provided this surveyor with a copy of a "Podiatric Services Report" dated "08/10/2016" revealing Resident # 6 received podiatry services. The "Progress Notes" for Resident # 6 dated 8/11/2016 at 7:34 a.m. documented, "Resident was seen by the Podiatrist on 8/10/16 in the evening shift. See chart notes." Review of Resident # 6's clinical record revealed a "Podiatric Services Report" dated "08/10/2016." Further review of the "Podiatric Services Report" revealed Resident # 6 received podiatry service on 8/10/16. It documented, "Debrided symptomatic. Dystrophic (affected) nails."	F 328	affected by this alleged deficient practice. **III** **Systematic Changes** The ADNS or designee will conduct an educational review for the nursing aides on the provision of providing nail care to the residents and placing the residents on the podiatry list as needed. If the patient refuses nail care, the proper documentation will be collected and the patient will be re-approached on the following visit by the Podiatrist.	

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F 328	Continued From page 57 The "Progress Notes" for Resident # 6 dated 5/12/15 through 8/5/16 failed to evidence documentation of Resident # 6's refusal of toe nail care. On 8/11/16 at 9:45 a.m. an interview was conducted with LPN # 5 regarding toe nail care for residents. LPN # 5 stated, "Toe nails are done by the podiatrist." On 8/11/16 at 10:15 a.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing regarding toe nail care. When asked how often residents' are seen by the podiatrist, ASM # 2 stated, "They're seen quarterly or as needed. When he comes quarterly the podiatrist sees everyone in the facility." When asked if there was an attempt to have the podiatrist come in and see Resident # 6 between May 17, 2016 and August 10, 2016, ASM # 2 stated, "I think so. There should be documentation." On 8/11/16 at 10:45 a.m. an interview was conducted with ASM # 2, the director of nursing and OSM (other staff member) # 2, director of social services. ASM # 2 and OSM # 2 stated that Resident # 6 was scheduled to be seen by the podiatrist on 7/19/16. When asked for the list of residents that were to be seen by the podiatrist on 7/19/16, OSM # 2 stated, "I pull the face sheets, I don't have a list." When asked why Resident # 6 wasn't seen by the podiatrist on 7/19/16, ASM # 2 was unable to give an answer as to why Resident # 6 was not seen. When asked about the documentation of Resident # 6 not being seen on 7/19/16, ASM # 2 stated, "If it's not documented I can't say it was done."	F 328	**IV** **Monitoring** The DON or Designee will audit residents' nails weekly for 4 weeks and monthly for 2 months for neatness of residents' nails. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.	

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F 328	Continued From page 58 The facility's policy "Foot Care" documented, "Purpose: To stimulate peripheral circulation, control odor and observe for infection. 11. Trim toe nails and apply lotion to tops and soles of feet. Do not apply between the toes. PATIENT THAT IS DIABETIC WITH PVD (peripheral vascular disease) DIAGNOSIS: 4. Do not cut toes nails (only licensed nurses)." On 8/10/16 at 5:50 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings. No further information was provided prior to exit. Fundamentals of Nursing, 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 863, documents, "Providing hygiene is a very basic part of a client's care. Caring practices help to alleviate the client's anxiety and promote comfort and relaxation while performing each hygiene measure." References: (1) A disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/copd.html>. (2) Broken vertebrae. Vertebrae are the bones of the spine. This information was obtained from the website: <https://medlineplus.gov/ency/article/000443.htm>. (3) High blood pressure. This information was	F 328	V **Date of Compliance 9/16/2016**	

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F 328	Continued From page 59 obtained from the website: <https://www.nlm.nih.gov/medlineplus/highbloodpressure.html>. (4) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/dementia.html>. (5) An enlarged prostate. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html>. (6) A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.	F 328		
F 441 SS=D	COMPLAINT DEFICIENCY 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	**F441** It is the facility's practice to establish and maintain an infection control program designed to provide a safe,	

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F 441	Continued From page 60 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to provide Foley care in a manner to prevent infection for one of 20 residents in the survey sample, Resident #4 and failed to maintain clean linen in a sanitary manner. 1. Facility staff failed to keep Resident #4's Foley bag and tubing off the floor. 2. Facility staff failed to maintain clean air	F 441	sanitary and comfortable environment and to prevent the development and transmission of disease and infection; establish an infection control program under which it investigates, controls and prevents infections in the facility; decides what procedures, such as isolation, should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. It is also the facility's practice to handle, store, process and transport linens so as to prevent the spread of infection. **I** **Corrective Actions** The Foley bag and tubing of resident #4 no longer touches	

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F 441	Continued From page 61 conditioning vents in the clean laundry room area. The findings include: 1. Facility staff failed to keep Resident #4's Foley bag and tubing off the floor. Resident #4 was admitted to the facility on 9/9/15 and readmitted on 11/7/15 with diagnoses that included but were not limited to: dementia, muscle weakness, high blood pressure, arthritis and elevated cholesterol. The most recent MDS (minimum data set), a quarterly assessment, with an assessment reference date of 6/6/16 coded the resident as being severely impaired cognitively to make daily decisions. The resident was coded requiring staff assistance for all activities of daily living. The resident was coded as having a urinary catheter. An observation of Resident #4 was made on 8/10/16 at 9:30 a.m. The resident was lying in bed on her right side with her eyes closed. The Foley bag was on the left side of the bed. The Foley bag was in a privacy bag, the bag and approximately ten inches of the Foley tubing were lying directly on the floor. An observation of Resident #4 was made on 8/10/16 at 11:20 a.m. The resident was lying in the bed on her right side with a long pillow propped behind her back. The Foley bag and approximately eight inches of the tubing were lying directly on the floor. An observation was made on 8/10/16 at 11:22 a.m. with LPN (licensed practical nurse) #4, the nurse caring for the resident. When asked to	F 441	the floor. The alleged deficient practice was corrected on 8/10/16. An audit of all the residents with indwelling Foley catheters was completed, and no new findings identified. The air conditioning vents in the laundry room were thoroughly cleaned and clean air conditioning vents are now maintained in the laundry room and in other areas of the facility. **II** **Identification** All the residents in the facility with indwelling Foley catheters have the potential to be affected by the alleged deficient practice.	

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F 441	Continued From page 62 check the Foley bag, LPN #4 raised the height of the bed to get the Foley bag and tubing off the floor. When asked what she had seen, LPN #4 stated, "The Foley was in the privacy bag and the bed was low so it was on the floor. When asked if there was tubing on the floor LPN #4 stated, "A little bit was dangling there, um hum." When asked if it was acceptable for the Foley bag and tubing to be directly on the floor, LPN #4 stated, "No, it's an infection issue." When asked if she had checked the Foley bag that day, LPN #4 stated, "I checked it at the beginning of my shift." LPN #4 stated that the resident usually had a private caregiver but she was going to be in later so, she (LPN #4) had been checking on Resident #4 every 45 minutes or so. Review of the physician's orders dated on signed on 7/21/16 documented, "09/10/15: INDWELLING FOLEY CATHETER #16F (french)/10ML (milliliters) STRAIGHT TO GRAVITY DRAINAGE...." Review of the August 2016 MAR, medication administration record, documented, INDWELLING FOLEY CATHETER #16F/10ML STRAIGHT TO GRAVITY DRAINAGE...." Review of Resident #4's care plan created on 9/10/15 and revised on 7/18/16 documented in part, "Use of indwelling urinary catheter....Report to physician signs of UTI (urinary tract infection) such as blood, cloudy urine, fever, increased restlessness, lethargy, c/o (complaints of) pain/burning." An interview was conducted on 8/10/16 at 5:05 p.m. with RN (registered nurse) #3, the unit manager. When asked if it was acceptable for a	F 441	All the residents residing in the facility whose laundry is done in the facility have the potential to be affected by this alleged deficient practice. **III** **Systemic Changes** The clinical staff will be reeducated by the DON or designee on catheter care and treatment. The Maintenance Director and the laundry staff will be reeducated on the procedure of keeping air conditioning vents clean, to include the laundry area. A weekly air conditioning	

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F 441	Continued From page 63 Foley bag and tubing to be lying on the floor, RN #3 stated, "It's an infection control thing, nothing should be touching the floor. I would have changed the whole thing (bag and tubing)." RN #3 was made aware of the findings. An interview was conducted on 8/11/16 at 11:40 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked if it was acceptable for a Foley bag and tubing to be lying on the floor, ASM #2 stated, "It's an infection control issue." ASM #1, the administrator and ASM #2 were made aware of the findings at that time. Review of the facility's policy did not reveal additional information. No further information was provided prior to exit. 2. Facility staff failed to maintain clean air conditioning vents in the clean laundry room area. On 8/11/16 at approximately 11:15 a.m. a tour of the facility's laundry room was conducted with OSM (other staff member) # 11, director of maintenance and OSM # 12, director of housekeeping and laundry. Observation of the clean laundry room area revealed two air conditioner ducts measuring approximately 12 inches long by 12 inches wide located on the ceiling with vents on all four sides of both ducts.	F 441	vent cleaning schedule and signing sheet have been initiated at this time. **IV** **Monitoring** The DON or designee will do a weekly audit of all Foley catheters for proper care and treatment for four weeks and monthly for two months and forward findings to the Quality and Assurance Committee. The Maintenance Director or designee will complete a weekly audit of air conditioning vents, to include the laundry for	

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F 441	Continued From page 64 Cold air was blowing from each of the vents on all four sides of the air conditioning ducts. Observation of the vents revealed they were covered with dust and dirt. Further observation of the clean laundry area revealed three uncovered linen racks partially filled with clean folded linen and two uncovered rolling linen carts with clean unfolded linens. The cold air was blowing air through the dirty and dusty vents over the five linen carts of clean linen. OSM # 11 and OSM # 12 were asked who was responsible for cleaning the air conditioner vents, OSM # 11 stated, "Its OSM # 12." OSM # 12 stated, "We clean the vents once a week." When asked to examine the vents above the carts with the clean linen OSM # 12 stated, "They should be cleaned." The facility's policy "Cleaning Guidelines" documented in part, "The following guidelines assist laundry staff with routine cleaning of the laundry area and equipment: ceiling vents, floor fans and table fans are cleaned to remove lint and dust once a week." On 8/11/16 at 12:05 p.m. ASM (administrative staff member) # 1, the administrator, was made aware of the findings. No further information was provided prior to exit.	F 441	cleanliness for four weeks and monthly for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **9/16/2016**	
F 514 SS=E	COMPLAINT DEFICIENCY 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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F 514	Continued From page 65 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to maintain a complete and accurate clinical record for four of 20 residents in the survey sample, Residents # 9, # 7, # 10 and # 5. 1. The facility staff documented another Resident's name and room number in Resident # 9's clinical record. 2. Facility staff failed to have Resident #7's durable do not resuscitate (DDNR) form completed as to the resident's resuscitation status. 3. The facility staff failed to complete the "Durable Do Not Resuscitate Order" (DDNR) for Resident # 10. 4. For Resident #5, another resident's information was filed on the clinical record.	F 514	**F514** It is the practice of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible, and systematically organized.	

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F 514	Continued From page 66 The findings include: 1. The facility staff documented another Resident's name and room number in Resident # 9's clinical record. Resident # 9 was admitted to the facility on 1/9/13 with diagnoses that included but were not limited to: seizure disorder, hypertension, hyperlipidemia, depression, coronary artery disease, gastroesophageal reflux disorder, and peripheral neuropathy. Resident # 9's most recent MDS (minimum data set) assessment, a Quarterly Assessment, with an ARD (assessment reference date) of 7/15/16 coded Resident # 9 as understood by others and as able to understand others. Resident # 9 was coded on the BIMS (Brief Interview for Mental Status) with a score of 14 out of 15, indicating that the Resident is cognitively intact. Review of Resident # 9's clinical record (nurses notes) revealed documentation as follows: "5/22/16 ...At 0645am (6:45 a.m.) I was attending to Resident (the Resident identified was not Resident # 9) in room (number listed) (name of Resident in listed room)..." During an interview on 8/10/16 at 2:50 p.m. with LPN (licensed practical nurse) # 3, LPN # 3 was asked if one could document another resident's name and room number in a resident's chart. LPN # 3 stated that one could identify the room number but never the name of another resident in a different resident's chart. During an interview on 8/10/16 at 2:55 p.m. with	F 514	**I** **Corrective Actions** The clinical records for residents #9, #7, #10, and #5 have all been audited by the DON and are now complete and accurate. The resident's name that was documented in the clinical record of resident #9 has been struck out on 8/25/16. The DDNR form for resident #7 has been completed to reflect the resident's resuscitation status (8/10/16). The DDNR order for resident #10 has been completed (8/10/16). The information of another resident that was filed on the clinical record of resident #5	

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F 514	Continued From page 67 LPN # 4, LPN # 4 was asked if one could document another resident's name and room number is a resident's chart. LPN # 4 stated that one could document the room number and bed but not the name of the other resident. An interview was conducted on 8/11/16 at 7:55 a.m. with ASM (administrative staff member) # 2, the director of nurses, ASM #2 was shown the above mentioned copy of the clinical record (nurses note) with another resident's name and room number in Resident # 9's chart. ASM # 2 stated, "The nurse should not have referred to another resident in the resident's chart. Not even the room number should be identified." When ASM # 2 was asked for a copy of the facility policy, ASM # 2 stated there was no policy that it was just a "best practice". When ASM # 2 was asked what is used as the "best practice" ASM # 2 stated that the documentation guide is used and that she (ASM # 2) would print out a copy. During an interview on 8/11/16 at 12:35 p.m. this concern was shared with ASM # 1, the administrator. The following facility document was reviewed: "CLINICAL RECORD SYSTEM - OVERVIEW" under "GENERAL GUIDELINES: Clinical records are maintained on each patient that are complete, readily accessible and systematically organized. A complete clinical record reports the actual experience of the individual and contains sufficient information to validate patient status and outcomes of care provided...The center maintains information contained in the clinical record as confidential, regardless of the form or storage method of the records ...Individuals charting in clinical records are expected to adhere	F 514	has been removed and filed in the appropriate record (8/10/16). The records of all residents currently residing in the facility with DDNR orders have been audited by the DON for accuracy and completeness (8/11/16). .	

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F 514	Continued From page 68 to ethical principles and professional standards..." No further documentation was provided prior to exit. According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team." Potter-Perry contains a quotation on page 477 regarding documentation as follows: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. According to "Fundamental Nursing Skills and Concepts": Eighth edition, Chapter 3, pg. 36 read: "Each healthcare setting requires accurate and complete documentation. The medical record is a legal document....Records must be timely, objective, accurate, complete and	F 514	**II Identification** All the residents residing in the facility have the potential to be affected by this alleged deficient practice.	

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F 514	Continued From page 69 legible..." 2. Facility staff failed to have Resident #7's durable do not resuscitate (DDNR) form completed as to the resident's resuscitation status. Resident #7 was admitted to the facility on 10/30/15 and readmitted on 11/18/15 with diagnoses that included but were not limited to: high blood pressure, chronic obstructive lung disease, difficulty walking, anxiety and fractured hip. The resident's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/8/16 coded the resident having a nine out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively to make daily decisions. Resident #7 was coded as requiring the assistance from staff for all activities of daily living. Review of Resident #7's clinical record revealed a form signed and dated on 11/2/15 by the physician and responsible party titled, "Durable Do Not Resuscitate Order....I further certify (must check 1 or 2): 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment (Signature of patient is required). 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extend or probable consequences of the proposed medical decision,	F 514	**III** **Systemic Changes** The DON or designee will re-educate Licensed Nurses on the proper procedure of documentation, completion of DDNR orders and DDNR forms, and accurate filing of residents' information.	

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F 514	Continued From page 70 or to make a rational evaluation of the risks and benefits of alternatives to that decision." There was a check box next to each statement, both boxes were blank. Review of the physician's orders signed and dated on 11/18/15 documented, "PATIENT IS A DO NOT RESUSCITATE." An interview was conducted on 8/10/16 at 10:57 a.m. with LPN (licensed practical nurse) #5, the nurse caring for Resident #7. When asked what the DDNR form was, LPN #5 stated, "This form is a do not resuscitate form." When asked if the form was complete, LPN #5 stated, "No." When asked what staff did if the form was not completed, LPN #5 stated, "I'd go to the patient and ask, and if they can't (answer) I'd call the POA (power of attorney)." An interview was conducted on 8/11/16 at 11:45 a.m. with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing regarding the process staff follow if a resident's DDNR form is not complete. ASM #1 stated, "Call the doctor right away and verify it." ASM #1 and ASM #2 were made aware of the findings at that time. No further information was received prior to exit. 3. The facility staff failed to complete the "Durable Do Not Resuscitate Order" (DDNR) for Resident # 10. Resident # 10 was admitted to the facility on	F 514	**IV** **Monitoring** The Medical Records Clerk or designee will audit residents' clinical records for accuracy and completeness weekly for four weeks and monthly for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action, as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.	

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F 514	Continued From page 71 6/20/14 with diagnoses that included but were not limited to: hypertension (1), thyroid disorder (2), Parkinson's disease (3), low iron, arthritis and depression. Resident # 10's most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/19/16, coded Resident # 10 as scoring a 14 on the brief interview for mental status (BIMS), of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Resident # 10 was coded as requiring limited assistance of one staff member for activities of daily living. The POS (physician order sheet) for Resident # 10 dated "August 2016" and signed by the physician on 7/21/16 documented, "Code Status: Do Not Resuscitate." Review of Resident # 10's clinical record revealed a red sheet of paper that documented, "Resident Name: (Resident # 10). Resident is DNR (Do Not Resuscitate) [(NO CPR)]." Further review of the clinical record revealed a "Durable Do Not Resuscitate Order (DDNR)" sheet dated 6/20/14 and signed by (Resident # 10) and the physician. Further review of the DDNR revealed it to be blank. On 8/10/16 at 12:35 p.m. an interview was conducted with LPN (licensed practical nurse) # 1 regarding the "Durable Do Not Resuscitate Order (DDNR)" sheet for Resident # 10. When asked how she identifies the code status of a resident LPN # 1 stated, "I check the chart. The color strip on the binder of the clinical record, green is full code and red is DNR, check the physician order sheet and code sheet; they're the same color as	F 514	**V** **Date of Compliance** **9/16/2016**	

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F 514	Continued From page 72	F 514		

the strip on the binder. The DNR residents have the DDNR form and it need to be completed and signed. LPN # 1 was then asked to review the DDNR form dated 6/20/14 for Resident # 10. After review the form LPN # 1 acknowledged that the DDNR form dated 6/20/14 for Resident # 10 was incomplete.

The facility's policy "Requirements and Guidelines for Clinical Record Content" documented, "Forms in the Clinical Record: Advance Directives. Written information is provided to the patient concerning the right to accept or refuse treatment and to formulate an advance directive...A copy of the patient's advance directive is maintained in the clinical record."

On 8/10/16 at 5:50 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing were made aware of the findings.

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

References:
(1) High blood pressure. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/highbloodpressure.html>.

(2) The thyroid is a butterfly-shaped gland in your neck, just above your collarbone. It is one of your endocrine glands, which make hormones that control the rate of many activities in your body; problems include hypertension, hypothyriodism and thyroid cancer). This information was obtained from the website: <https://medlineplus.gov/thyroiddiseases.html>.

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F 514	Continued From page 73 (3) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. 4. For Resident #5, another resident's information was filed on the clinical record. Resident #5 was admitted on 6/16/15 with the diagnoses of but not limited to dementia, prostate cancer, psychosis, obstructive uropathy, dementia, depression, high blood pressure, thyroid cancer, and tube feeding. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/30/16. Resident #5 was coded as severely cognitively impaired in ability to make daily life decisions, scoring a 4 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring total care for bathing and eating; extensive assistance for hygiene; limited assistance for transfers; supervision for ambulation; and as incontinent of bowel, and as having a catheter for bladder. A review of the clinical record revealed the second page of a 2 page document from a physician regarding another resident. On 8/11/16 at approximately 12:00 p.m., RN #3, the unit manager for Resident #5 stated that she does the filing in the clinical records for that unit, and that the misfiling of the document for another resident in Resident #5's record was an oversight.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495011	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ALEXANDRIA	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

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F 514	Continued From page 74 On 8/11/16 at approximately 12:30 p.m., the Administrator and Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. On 8/10/16 at 5:50 p.m., the Administrator and Director of Nursing, and the 2 unit managers (RN #2 and RN #3) were made aware of the findings. No further information was provided by the end of the survey.	F 514		