

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

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/06/2017
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
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F 000	INITIAL COMMENTS  An unannounced Medicare/Medicaid standard survey was conducted 4/4/17 through 4/6/17. One complaint was investigated during the survey. Significant 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 120 certified bed facility was 114 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents # 1 through # 20) and five closed record reviews (Residents # 21 through # 25).	F 000			
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  (b)(3) Comprehensive Care Plans  The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review and clinical record review, it was determined that facility staff failed to follow professional standards of practice for two of 25 residents in the survey sample, Resident #12 and Resident #5.  1. The facility staff failed to clarify a physician's order for sliding scale humulin-r (regular insulin with short duration of action (2)) insulin for Resident #12. Resident #12's sliding scale order for humulin-r insulin did not contain the sliding scale doses to be given based on blood sugar	F 281	1. Resident #12's physician was notified that the accucheck order with sliding scale insulin coverage was not confirmed by the nurse and blood sugars had not been obtained as ordered, order was clarified and re-entered into electronic medical record. Nurse confirming the order will receive educational coaching on completion of data entry for accucheck orders with sliding scale coverage. (2) The licensed nurse working with Resident #5 on 1/17/17 who failed to document assessment of pressure injury and treatment is no longer employed in the Center. Resident #5's pressure injury remains resolved.		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 281	<p>Continued From page 1 readings.</p> <p>2. The facility staff failed to document an assessment of a pressure injury and document the physician order for a treatment applied for Resident #5.</p> <p>The findings include:</p> <p>1. Resident #12 was admitted to the facility on 3/2/17 and readmitted on 3/17/17 with diagnoses that included but were not limited to: diabetes, anemia, high blood pressure, difficulty swallowing and depression.</p> <p>The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 3/31/17 coded the resident as having scored an 11 out of 15 on the BIMS (brief interview for mental status indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.</p> <p>Review of the physician's orders dated 3/29/17 documented, "accuchecks (1) ac (before meals)/hs (bedtime) with sliding scale coverage with humulin-r."</p> <p>Review of the April 2017 MAR (medication administration record) did not evidence documentation of the accucheck order.</p> <p>Review of Resident #12's blood sugar summary record did not evidence any blood sugar results since 3/13/17.</p> <p>Review of the nurse's notes from 3/29/17 through 4/5/17 did not evidence documentation of blood</p>	F 281	<p>2. Current residents will have body audits completed to verify skin integrity; any areas identified nurse will verify an appropriate treatment in place per MD orders and documented and notification of MD/RP. Current residents will have sliding scale order reviewed for order entry accuracy.</p> <p>3. Licensed Nurses will be educated on assessment and documentation of altered skin integrity. UM's and supervisory nurses will be educated on Center's protocol for monitoring dashboard for alerts to altered skin integrity and verification of assessment/treatments/ MD &amp; RP notification. Completion of data entry for accucheck orders with sliding scale coverage.</p>		

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F 281	<p>Continued From page 2 sugar results.</p> <p>Review of the care plan created on 3/3/17 documented, "Focus. Has diabetes/blood sugar fluctuation requiring medical and/or dietary management. Interventions/Tasks. Administer diabetic management medication as ordered. Perform blood sugar checks as ordered or clinically indicated. Report significant values outside of established protocol or parameters."</p> <p>An interview was conducted on 4/5/17 at 2:50 p.m., with RN (registered nurse) #5, the interim unit manager and RN #6, regarding the process followed when physicians write orders. RN #5 stated, "Any time you put in an order you have to have scheduled times, the sliding scale has to be embedded into the order." RN #5 was asked to review Resident #12's accucheck order. RN #5 looked at the order summary and stated, "I can tell you this order is not written in there (the MAR). I would strike that order out and re-order it and put in the sliding scale and get him (the doctor) to re-clarify it." RN #5 stated that when the physician entered the order there was no time for the insulin to be given and there were no insulin dosages written and therefore it would not be seen by the pharmacist and would not get entered into the MAR. RN #5 stated the nurse should have clarified the order. RN #6 stated, "This order wasn't put in right, it won't show up in the MAR."</p> <p>On 4/5/17 at 3:45 p.m. the facility's policy on the care of a diabetic on insulin and following physician orders was requested of ASM (administrative staff member) #2, the director of nursing.</p>	F 281	<p>4. 1) The Don or Designee will randomly audit 5 electronic medical records for documentation of risk for, development of wound treatment/intervention in place weekly x 4 weeks and then Monthly x 2. The DON will review findings and report to QAPI Committee for any further recommendation.</p> <p>2) The DON and designee will conduct a review of resident with new accucheck orders weekly x 4 weeks and monthly x 2 months for residents to verify accuracy of data entry for orders with specific parameters. The DON or designee will review findings and report to QAPI Committee for any further recommendation.</p> <p>5. Date of compliance : May 10, 2017</p>		

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F 281	<p>Continued From page 3</p> <p>An interview was conducted on 4/5/17 at 4:15 p.m. with ASM #2, the director of nurses. ASM #2 was asked about the process the staff nurses follow when an order is written by the physician. ASM #2 stated that when a physician wrote an order into the computer system the nurse confirms the order. When asked what the nurse was confirming, ASM #2 stated, "You verify them (the orders) for accuracy, scheduling, timing, date and the five rights of medication administration." ASM #2 stated that they (the facility) did not have the policies as requested as nurse's used standard nursing practices. When asked what nursing practice standards the facility used, AMS #2 stated, "Lippincott." ASM #2 was made aware of the findings at that time.</p> <p>An interview was conducted on 4/6/17 at 9:32 a.m. with LPN (licensed practical nurse) #7, the nurse who confirmed Resident #12's physician order for sliding scale insulin. LPN #7 was asked about the process staff follows when a doctor enters an order into the computer system. LPN #7 stated, "When the doctor has entered the order we have to confirm it." When asked what was included in confirming an order, LPN #7 stated, "What's involved is getting a better understanding. Why the order is there and then follow up with the patient and see if the order is necessary." LPN #7 was asked to review the sliding scale order for Resident #12. When asked if the order was correct, LPN #7 stated, "It needs to be clarified. It doesn't have the sliding scale (the amount of insulin to be given based on the blood sugar results)."</p> <p>No further information was provided prior to exit.</p> <p>In Potter-Perry, Fundamentals of Nursing, 6th</p>	F 281			

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F 281	<p>Continued From page 4</p> <p>edition, page 841, a noted standard of practice is: "When medications are first ordered, the nurse compares the medication recording form or computer orders with the prescriber's written orders." On page 852, regarding the administration of oral medications, "Check accuracy and completeness of each MAR or computer printout with prescriber's written medication order."</p> <p>(1) Accuchecks -- Since its introduction three decades ago, self-monitoring of blood glucose (SMBG) using finger-stick blood samples, test strips, and portable meters has aided diabetes management, principally by enabling patients-particularly those treated with insulin-to become full partners along with health professionals in striving for excellent glycemic control. This information was obtained from: <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845057/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845057/</a></p> <p>(2) Humulin - r (regular) -- Humulin R U-100 is indicated as an adjunct to diet and exercise to improve glycemic control in adults and children with type 1 and type 2 diabetes mellitus. Humulin R U-100 is human insulin with a short duration of action. This information was obtained from: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b519bd83-038c-4ec5-a231-a51ec5cc291f">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b519bd83-038c-4ec5-a231-a51ec5cc291f</a></p> <p>2. The facility staff failed to document an assessment of a pressure injury and document the physician order for a treatment that was applied for Resident #5.</p> <p>Resident #5 was admitted to the facility on 3/22/12 with diagnoses that included but were not limited to: dementia, schizophrenia, high blood</p>	F 281			

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**8575 RIXLEW LANE  
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F 281 Continued From page 5  
pressure, osteoporosis, diabetes, anemia,  
hypothyroid, anxiety and depression.

The most recent MDS (minimum data set  
assessment) a quarterly assessment, with an  
assessment reference date of 2/8/17, coded the  
resident as having both short and long term  
memory difficulties. The resident was coded as  
being severely impaired to make daily cognitive  
decisions. Resident #5 was coded as requiring  
extensive assistance of one staff member for all  
of her activities of daily living except eating and  
bathing in which she was totally dependent upon  
the staff for these activities. The resident was  
coded as being frequently incontinent of both  
bowel and bladder. In Section M - Skin  
Conditions, the resident was coded as having one  
Stage 3 pressure area that measured 0.4 cm  
(centimeters) in length, 0.5 cm in width and 0.2  
cm in depth.

The nurse's notes were reviewed. There was no  
nurse's note for 1/17/17.

The ADL (activities of daily living) documentation  
for 1/17/17 documented, "oa" indicating an open  
area and "bu" indicating buttocks. A "Y"  
indicating, 'yes' the nurse was notified.

On 4/6/17 at 8:37 a.m. ASM (administrative staff  
member) #1, the administrator, ASM #2, the  
director of nursing and ASM #3, the corporate  
nurse consultant, presented a "Timeline" of the  
actions the facility took in the prevention and  
treatment of a pressure ulcer for Resident #5.

The timeline documented the CNA  
documentation on the ADL record for 1/17/17.  
Resident #5's ADL (activity of daily living) record

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F 281	<p>Continued From page 6</p> <p>for January 2017 documented in part an "OA - open area" on 1/3/17 and 1/17/17, and a "Y" indicating "yes" the nurse was notified on each of these dates. ASM #2 stated, "I interviewed the CNA (#4) who documented this on 1/17/17. She informed me that the open area was in the 'butt crack' and not on the buttock. The CNA documentation does not allow for more descriptive documentation, it just allows buttock area which would have included the coccyx. This CNA stated when I interviewed her, that the next day there was a 'patch' over the area. A foam dressing is our protocol until the wound nurse assesses the wound." When asked where the nurse documented the assessment of the area prior to placing a wound dressing in place, ASM #2 stated, "There is no documentation by the nurse for this. The nurse who did this is no longer employed at the facility." ASM #2 stated, "When I interviewed the CNA she informed me that this was the same area that they had been applying cream to since 11/4/16." When asked where the wound care nurse assessment of this area was documented, ASM #2 stated, "We were not aware of the open area until 1/23/17.</p> <p>During an interview was ASM #1, the administrator, on 4/6/17 at 8:37 a.m. ASM #1 stated, "The piece that we don't have is the documentation of 1/17/17 that the nurse assessed the area and implemented a treatment.</p> <p>The facility policy, "Pressure Ulcer Prevention and Care Program" documented in part, "Pressure ulcers can develop anywhere there is pressure. The obvious areas include: Sacrum and coccyx...The CNA is to verbally report ALL unusual resident observations/changes to their licensed nurse, including the skin observations</p>	F 281			

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F 281	Continued From page 7 listed above, and then document what they report in the EMR on the Body Audit. The licensed nurse will: observe the area/condition reported by the CNA, obtain physician's orders, notify the Responsible Party, provide treatment(s) indicated, document the problem thoroughly in the Interdisciplinary Notes, include in the 24 hour report, and update the resident's Care Plan to reflect the treatment/preventative measures that are implemented."			F 281			
F 282	No further information was provided prior to exit. 483.21(b)(3)(ii) SERVICES BY QUALIFIED SS=E PERSONS/PER CARE PLAN  (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the care plan for four of 25 residents in the survey sample, Resident #10, Resident #12, Resident #8 and Resident #9.  1. The facility staff failed to follow the written plan of care for the administration of a medication for high blood pressure for Resident #10.  2. The facility staff failed to follow the written plan of care to obtain accuchecks for Resident #12.			F 282	F 282  1. (1) Resident #10's physician was notified that Clonidine order entry did not reflect recordings of blood pressure; the physician reviewed current blood pressure readings in the MAR and PRN Clonidine was discontinued. Nurse entering the original Clonidine order will receive educational coaching on order entry for PRN BP medications. Resident # 10's care plan has been reviewed and nursing staff will be re-educated on following resident's individualized plan of care for monitoring vital signs and medication administration.		

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F 282	Continued From page 8  3. The facility staff failed to follow Resident #8's comprehensive care plan for the implementation of non-pharmacological interventions for pain.  4. The facility staff failed to follow the comprehensive care plan for the implementation of fall mats for Resident # 9.  The findings include:  1. Resident #10 was admitted to the facility on 1/30/16 and readmitted on 3/31/16 with diagnoses that included but were not limited to: stroke, high blood pressure, depression and diabetes. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 2/8/17 coded the resident as having a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as needing minimal assistance from staff for activities of daily living except for dressing which the resident needed moderate staff assistance.  Review of Resident #10's care plan created on 2/12/16 and revised on 3/6/17 documented, "Focus. (Resident #10's initials) has altered cardiovascular status which may impacts (sic) day to day function R/t (related to) hypertension (high blood pressure)...Interventions/Tasks. Administer medications as ordered. Vital Signs per MD (medical doctor) orders and as indicated by s/s/ (signs and symptoms). Notify physician of significant deviations/abnormalities."  Review of the physician's orders dated April 2017 documented, "CloNIDine HCL (indicated in the	F 282	(2) Resident #12's physician was notified that the accucheck order with sliding scale insulin coverage was not confirmed by the nurse and blood sugars had not been obtained as ordered, order was clarified and re-entered into electronic medical record. Nurse confirming the order will receive educational coaching on completion of data entry for accucheck orders with sliding scale coverage. Resident # 12's care plan has been reviewed and nursing staff will be re-educated on following resident's individualized plan of care for blood sugar monitoring and medication management of blood sugars.  (3) Resident #8 will be re-assessed for pain and findings will be reviewed by the interdisciplinary team and his plan of care will be revised as indicated. Nursing staff will be re-educated on implementation of non-pharmacological		

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F 282	Continued From page 9 treatment of hypertension (1)) Tablet 0.1 MG (milligram) Give 1 tablet by mouth every 12 hours as needed for systolic (top number of blood pressure - when the heart beats while pumping blood (2)) b/p (blood pressure) greater than 160. Start Date. 11/15/2016."  Review of the April 2017 MAR (medication administration record) documented, "CloNIDine HCL Tablet 0.1 MG (milligram) Give 1 tablet by mouth every 12 hours as needed for systolic b/p (blood pressure) greater than 160. Start Date. 11/15/2016." Under each day of the month there were two boxes. One box was titled, "BP (blood pressure)" and the other box was titled "PRN (as needed)." There was no documentation evidenced of the blood pressure or if the medication was administered.  Review of the resident's blood pressure summary record documented a blood pressure of 130/70 on 4/1/17 and a blood pressure of 115/72 on 4/3/17.  Review of the April 2017 nurse's notes did not evidence documentation regarding the resident having blood pressures taken twice a day.  An interview was conducted on 4/5/17 at 12:55 p.m. with RN (registered nurse) #7. When asked who used the residents' care plans, RN #7 stated, "We do, physical therapy, the doctor, everyone in the health care field who are helping the patient." When asked why residents have care plans, RN #7 stated, "To make sure the patient has goals." When asked if staff were expected to follow the care plan, RN #7 stated, "Yes, you have goals to help get them out of here."	F 282	interventions prior to medication as an adjunct to pain management and will be re-educated on following resident's individualized plan of care for pain management.  (4) Resident #9's fall mats were put in place as per care plan and nursing staff have been re-educated on following resident's individualized plan of care for implementation of safety devices.  2. An audit of residents with blood pressure medications will be completed to verify blood pressures are being monitored per order and nurses are following resident's individualized plan of care.  An audit of new orders for the past 14 days will be completed to verify complete and accurate data entry and that nurses are following resident's individualized plan of care for vital sign monitoring and medication management		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/06/2017
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F 282	Continued From page 10  An interview was conducted on 4/5/17 at 1:10 p.m. with RN #5, the interim unit manager. When asked who used the care plans, RN #5 stated, "All the nurses need to be aware of the care plan." When asked why residents had care plans, RN #5 stated, "To make sure our residents are safe. It's part of nursing, it's huge." When asked if staff were expected to follow the care plan, RN #5 stated, "Yes. The care plan interventions are put on the care plan for a reason and we follow the care plan. If (the interventions) aren't working we re-assess and change the care plan."  An interview was conducted on 4/5/17 at 4:15 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked why residents had care plans, ASM #2 stated, "To know how to care for our patients." When asked who used the care plan, ASM #2 stated, "Every department has some part of the care plan." When asked if staff were expected to follow the resident's care plan, ASM #2 stated, "Yes." ASM #2 was made aware of the findings at that time.  Review of the facility's policy titled, "COMPREHENSIVE CARE PLANNING PROCESS" documented, "POLICY. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. PROCEDURE. 6. Duties and responsibility of the Care Planning/Interdisciplinary Team include but are not limited to: b. Reviewing care plans to assure that: l. They represent the resident's medical and nursing assessment; v. They reflect standards of current professional standards."	F 282	A review of 24 hour report for past 72 hours to verify nurses are implementing non-pharmacological interventions per resident's individualized plan of care.  A review of residents with safety device orders will be completed to ensure safety devices are in place and nursing staff are following the resident's individualized plan of care.  3. The Nurse Educator or designee will educate nursing staff on following the residents individualized plan of care and data entry of new orders. The Nurse Educator will educate UM's and supervisory staff on Center protocol for verifying complete and accurate medication orders  4. The DON and designee will review of resident with blood pressure orders weekly x 4 weeks and monthly x 2 months for residents to verify accuracy of		

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F 282	Continued From page 11  No further information was provided prior to exit.  According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."  (1) Clonidine -- Clonidine hydrochloride is indicated in the treatment of hypertension. Clonidine hydrochloride may be employed alone or concomitantly with other antihypertensive agents. This information was obtained from: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=438dece9-95d4-40f2-84b4-9e2c6d88e760">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=438dece9-95d4-40f2-84b4-9e2c6d88e760</a>  (2) Systolic blood pressure- This information was obtained from the website: <a href="https://www.nhlbi.nih.gov/health/health-topics/topics/hbp/">https://www.nhlbi.nih.gov/health/health-topics/topics/hbp/</a>  2. Resident #12 was admitted to the facility on 3/2/17 and readmitted on 3/17/17 with diagnoses that included but were not limited to: diabetes, anemia, high blood pressure, difficulty swallowing and depression.	F 282	data entry for orders with specific parameters. The DON or designee will review findings and report to QAPI Committee for any further recommendation.  The DON and designee will review of 24 hour report for implementation of non-pharmacological interventions weekly x 4 weeks and monthly x 2 months for resident's interventions per resident's individualized plan of care. The DON or designee will review findings and report to QAPI Committee for any further recommendation.  5. Date of compliance :May 10,2017		

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F 282	Continued From page 12  The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 3/31/17 coded the resident as having scored an 11 out of 15 on the BIMS (brief interview for mental status indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.  Review of the physician's orders dated 3/29/17 documented, "accuchecks (1) ac (before meals)/hs (bedtime) with sliding scale coverage with humulin-r (regular insulin - with a short duration of action (2))."  Review of the April 2017 MAR (medication administration record) did not evidence documentation of the accucheck order.  Review of Resident #12's blood sugar summary record did not evidence any blood sugar results since 3/13/17.  Review of the nurse's notes from 3/29/17 through 4/5/17 did not evidence documentation of blood sugar results.  Review of the care plan created on 3/3/17 documented, "Focus. Has diabetes/blood sugar fluctuation requiring medical and/or dietary management. Interventions/Tasks. Administer diabetic management medication as ordered. Perform blood sugar checks as ordered or clinically indicated. Report significant values outside of established protocol or parameters."  An interview was conducted on 4/5/17 at 12:55 p.m. with RN (registered nurse) #7. When asked	F 282			

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F 282	<p>Continued From page 13</p> <p>who used the residents' care plans, RN #7 stated, "We do, physical therapy, the doctor. Everyone in the health care field who are helping the patient." When asked why residents have care plans, RN #7 stated, "To make sure the patient has goals." When asked if staff were expected to follow the care plan, RN #7 stated, "Yes, you have goals to help get them out of here."</p> <p>An interview was conducted on 4/5/17 at 1:10 p.m. with RN #5, the interim unit manager. When asked who used the care plans, RN #5 stated, "All the nurses need to be aware of the care plan." When asked why residents had care plans, RN #5 stated, "To make sure our residents are safe. It's part of nursing, it's huge." When asked if staff were expected to follow the care plan, RN #5 stated, "Yes. The care plan interventions are put on the care plan for a reason and we follow the care plan. If (the interventions) aren't working we re-assess and change the care plan."</p> <p>An interview was conducted on 4/5/17 at 4:15 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked why residents had care plans, ASM #2 stated, "To know how to care for our patients." When asked who used the care plan, ASM #2 stated, "Every department has some part of the care plan." When asked if staff were expected to follow the resident's care plan, ASM #2 stated, "Yes." ASM #2 was made aware of the findings at that time.</p> <p>No further information was provided prior to exit.</p> <p>(1) Accuchecks -- Since its introduction three decades ago, self-monitoring of blood glucose (MSG) using finger-stick blood samples, test strips, and portable meters has aided diabetes</p>	F 282			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	Continued From page 14  management, principally by enabling patients-particularly those treated with insulin-to become full partners along with health professionals in striving for excellent glycemic control. This information was obtained from: <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845057/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845057/</a>  (2) Humulin - r -- Humulin R U-100 is indicated as an adjunct to diet and exercise to improve glycemic control in adults and children with type 1 and type 2 diabetes mellitus. Humulin R U-100 is human insulin with a short duration of action. This information was obtained from: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b519bd83-038c-4ec5-a231-a51ec5cc291f">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b519bd83-038c-4ec5-a231-a51ec5cc291f</a>  3. The facility staff failed to follow Resident #8's comprehensive care plan for the implementation of non-pharmacological interventions for pain.  Resident # 8 was admitted to the facility on 03/15/16 with diagnoses that included but were not limited to: atrial fibrillation (1), gastroesophageal reflux disease (2), diabetes mellitus (3), arthritis, anxiety (4), depression, respiratory failure (5), dysphagia (6), hypokalemia (7), and retention of urine.  Resident # 8's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/20/17, coded Resident # 8 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 # 8 was coded as requiring extensive assistance of one staff member for activities of daily living.	F 282			

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F 282	Continued From page 15  The POS (Physician's Order Sheet) For Resident # 8 dated 04/04/17 and electronically signed by the physician on 02/25/17 documented, "Next Review Date: 04/26/2017." The POS further documented, "Oxycodone (8) 5 (five) MG (milligrams). Give 1 (one) tablet via (by) G-Tube [gastrostomy tube (9)] every 6 (six) hours as needed for pain moderate to severe. Order Date: 05/23/2016." "Acetaminophen Liquid (10). Give 650 MG via G-Tube every 6 hours as needed for mild pain. Order Date: 05/23/2016."  The care plan for Resident # 8 dated 03/24/16 documented, "Focus: Potential for Pain r/t (related to) arthritis, immobility." Under "Interventions/Tasks" it documented, "Assist resident with alternative positioning as a non-pharmacological intervention. Date Initiated: 03/24/2016."  The MAR (medication administration record) for Resident # 8 dated "January 2017 documented: "Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet via (by) G-Tube [gastrostomy tube] every 6 (six) hours as needed for pain moderate to severe. Order Date: 05/23/2016." "Acetaminophen Liquid. Give 650 MG via G-Tube every 6 hours as needed for mild pain. Order Date: 05/23/2016." Further review of the MAR dated January 2017 revealed acetaminophen liquid was administered on 01/15/17 at 1:12 p.m. and 01/17/17 at 9:04 a.m. and 4:26 p.m. Oxycodone was administered on 01/01/17 at 9:00 p.m., 01/02/17 at 9:05 p.m., 01/03/17 at 9:03 p.m., 01/04/17 at 9:45 p.m., 01/05/17 at 10:01 p.m., 01/06/17 at 12:29 p.m. and 9:08 p.m., 01/07/17 at 9:20 p.m., 01/08/17 at 9:39 p.m., 01/09/17 at 10:43 p.m., 01/10/17 at	F 282			

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F 282	<p>Continued From page 16</p> <p>10:58 a.m., and 8:49 p.m., 01/11/17 at 10:30 a.m., and 6:35 p.m., 01/12/17 at 9:42 a.m. and 9:07 p.m., 01/13/17 at 9:02 p.m., 01/14/17 at 9:44 a.m., 01/16/17 at 4:13 p.m., 01/17/17 at 9:02 p.m., 01/18/17 at 6:49 p.m., 01/19/17 at 9:18 p.m., 01/21/17 at 9:01 p.m., 01/22/17 at 9:04 p.m., 01/24/17 at 9:01 p.m., 01/25/17 at 8:05 p.m., 01/26/17 at 8:37 p.m., 01/27/17 at 3:10 p.m. and 9:14 p.m., 01/28/17 at 11:50 a.m., 01/29/17 at 9:24 a.m. and 8:42 p.m., 01/30/17 at 3:30 p.m. and 9:38 p.m. and on 01/31/17 8:36 p.m.</p> <p>The MAR (medication administration record) for Resident # 8 dated "February 2017 documented: "Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet via (by) G-Tube [gastrostomy tube] every 6 (six) hours as needed for pain moderate to severe. Order Date: 05/23/2016." "Acetaminophen Liquid. Give 650 MG via G-Tube every 6 hours as needed for mild pain. Order Date: 05/23/2016." Further review of the MAR dated February 2017 revealed acetaminophen liquid was administered on 02/01/17 at 9:52 a.m. and 02/26/17 at 9:22 a.m. Oxycodone was administered on 02/01/17 at 5:26 p.m., 02/02/17 at 8:44 p.m., 02/05/17 at 11:34 a.m. and 9:38 p.m., 02/07/17 at 5:42 p.m., 02/08/17 at 9:01 p.m., 02/09/17 at 8:31 p.m., 02/10/17 at 9:32 p.m., 02/11/17 at 11:54 a.m., 02/13/17 at 9:51 a.m. and 9:02 p.m., 02/14/17 at 9:42 p.m., 02/15/17 at 4:03 p.m., 02/16/17 at 11:08 a.m. and 8:53 p.m., 02/18/17 at 5:15 p.m., 02/19/17 at 5:25 p.m., 02/21/17 at 9:05 p.m., 02/22/17 at 8:42 p.m., 02/23/17 at 8:40 p.m., 02/26/17 at 2:09 p.m., 02/27/17 at 1:19 p.m. and 7:36 p.m. and on 02/28/17 at 8:11 p.m.</p> <p>The MAR (medication administration record) for Resident # 8 dated "March 2017 documented:</p>	F 282			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	<p>Continued From page 17</p> <p>"Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet via (by) G-Tube [gastrostomy tube] every 6 (six) hours as needed for pain moderate to severe. Order Date: 05/23/2016."</p> <p>Further review of the MAR dated March 2017 revealed oxycodone administered on 03/01/17 at 9:04 p.m., 03/02/17 at 8:40 p.m., 03/04/17 at 1:50 p.m. and 9:07 p.m., 03/05/17 at 9:02 p.m., 03/06/17 at 9:18 p.m., 03/07/17 at 4:04 p.m., 03/08/17 at 9:24 p.m., 03/09/17 at 8:48 p.m., 03/10/17 at 8:48 p.m., 03/13/17 at 8:59 p.m., 03/14/17 at 5:15 p.m., 03/15/17 at 9:03 p.m., 03/16/17 at 9:02 p.m., 03/17/17 at 4:35 p.m., 03/19/17 at 3:34 p.m., 03/20/17 at 1:00 p.m. and 9:17 p.m. and on 03/28/17 at 10:31 a.m.</p> <p>The MAR (medication administration record) for Resident # 8 dated "April 2017 documented: "Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet via (by) G-Tube [gastrostomy tube] every 6 (six) hours as needed for pain moderate to severe. Order Date: 05/23/2016."</p> <p>Further review of the MAR dated April 2017 revealed oxycodone administered on 04/02/17 at 7:51 a.m. and on 04/03/17 at 4:04 p.m.</p> <p>The "Progress Notes" for Resident # 8 dated 01/01/2017 through 04/04/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of acetaminophen liquid and oxycodone.</p> <p>On 4/5/17 at 3:20 p.m. an interview was conducted with LPN (licensed practical nurse) # 6. When asked to describe the procedure of administering PRN pain medication, LPN # 6 stated, "Assess the resident for pain on a scale of one to ten, check the physician's orders and</p>	F 282			

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F 282	<p>Continued From page 18</p> <p>when the resident was given the last dose. Use non-pharmacological interventions. After 30 minutes to an hour I would check the resident to see if the medication was effective and document in the progress notes." When asked to describe the purpose of a resident's care plan, LPN # 6 stated, "So we know how to take care of the resident." LPN # 6 was asked to review the care plan dated 03/24/16, the MARs dated January, February, March and April 2017 and the progress notes dated 01/01/17 through 4/4/17 for Resident # 8. When asked to show the documentation that the care plan was followed to implement non-pharmacological interventions prior to the administration of oxycodone and acetaminophen to Resident # 8, LPN # 6 was unable to provide any evidence of the documentation.</p> <p>On 4/5/17 at 4:10 p.m. an interview was conducted with ASM # 2, the director of nursing regarding a resident's care plan and the implementation of non-pharmacological interventions prior to the administration of PRN pain medication. ASM (administrative staff member) # 2 stated, "The care plan should be followed."</p> <p>On 4/5/17 at 5:15 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.</p> <p>No further information was provided prior to exit.</p> <p>References:</p> <p>1. A problem with the speed or rhythm of the heartbeat. This information was obtained from the website:</p>	F 282			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/06/2017
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
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F 282	Continued From page 19 <a href="https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html">https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html</a> .  2. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/gerd.html">https://www.nlm.nih.gov/medlineplus/gerd.html</a> .  3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a> .  4. Fear. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anxiety.html#summary">https://www.nlm.nih.gov/medlineplus/anxiety.html#summary</a> .  5. When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html">https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html</a> .  6. A swallowing disorder. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html">https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html</a> .  7. Low potassium level is a condition in which the amount of potassium in the blood is lower than normal. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000479.htm">https://medlineplus.gov/ency/article/000479.htm</a> .  8. Used to relieve moderate to severe pain. This information was obtained from the website: <a href="https://medlineplus.gov/druginfo/meds/a682132.htm">https://medlineplus.gov/druginfo/meds/a682132.htm</a>	F 282			

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F 282	Continued From page 20 tml.  9. A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/002937.htm">https://medlineplus.gov/ency/article/002937.htm</a> .  10. Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: <a href="https://medlineplus.gov/druginfo/meds/a681004.htm">https://medlineplus.gov/druginfo/meds/a681004.h</a> tml.  4. The facility staff failed to follow the comprehensive care plan for the implementation of fall mats for Resident # 9.  Resident # 9 was readmitted to the facility on 04/14/14 with diagnoses that included but were not limited to: anemia (1), hypertension (2), diabetes mellitus (3), dementia (4), anxiety (5), cerebral ataxia (6), and depression.  Resident # 9's most recent MDS (minimum data set), a quarterly assessment with an ARD	F 282			

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F 282	<p>Continued From page 21</p> <p>(assessment reference date) of 01/12/17, coded Resident # 9 as scoring a six on the brief interview for mental status (BIMS) of a score of 0 - 15, six being severely impaired of cognition for making daily decisions. Resident # 9 was coded as requiring extensive assistance of one staff member for activities of daily living.</p> <p>On 04/04/17 at 3:40 p.m. an observation of Resident # 9 revealed she was lying in her bed and the fall mats were folded under the bed.</p> <p>On 04/04/17 at 4:20 p.m. an observation of Resident # 9 revealed she was lying in her bed and the fall mats were folded under the bed.</p> <p>On 04/04/17 at 5:00 p.m. an observation of Resident # 9 revealed she was lying in her bed and the fall mats were folded under the bed.</p> <p>On 04/05/17 at 8:30 a.m. an observation of Resident # 9 revealed she was lying in her bed and the fall mats were folded under the bed.</p> <p>The care plan for Resident # 9 dated 02/17/2014 with a revision date of 01/25/2017 documented, "(Resident # 9) is at risk for falls r/t (related to) decreased mobility, cognitive impairment impacting ability to understand own physical limitations." Under "Interventions/Tasks" it documented, "Fall safety mats at bedside when in bed."</p> <p>The facility's "Fall Risk Assessment" for Resident # 9 dated 01/10/2017 documented, "High Risk."</p> <p>On 4/5/17 at 4:10 p.m. an interview was conducted with ASM # 2, the director of nursing regarding a resident's care plan. ASM</p>	F 282			

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F 282	<p>Continued From page 22</p> <p>(administrative staff member) # 2 stated, "The care plan should be followed."</p> <p>On 4/5/17 at 5:15 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.</p> <p>No further information was provided prior to exit.</p> <p>References:</p> <p>1. Low iron. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anemia.html">https://www.nlm.nih.gov/medlineplus/anemia.html</a></p> <p>2. High blood pressure. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/highbloodpressure.html">https://www.nlm.nih.gov/medlineplus/highbloodpressure.html</a></p> <p>3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a></p> <p>4. A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000739.htm">https://medlineplus.gov/ency/article/000739.htm</a></p> <p>5. Fear. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anxiety.html#summary">https://www.nlm.nih.gov/medlineplus/anxiety.html#summary</a></p>	F 282			

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F 282	Continued From page 23 6. A sudden uncoordinated muscle movement due to disease or injury to the cerebellum in the brain. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/001397.htm">https://medlineplus.gov/ency/article/001397.htm</a> .	F 282			
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.  483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:  (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.  (l) Dialysis. The facility must ensure that residents who require dialysis receive such	F 309	1.  Resident #8 will be re-assessed for pain and findings will be reviewed by the interdisciplinary team and his plan of care will be revised as indicated. Nursing staff will be re-educated on implementation of non- pharmacological interventions prior to medication as an adjunct to pain management.  Resident #9 will be re-assessed for pain and findings will be reviewed by the interdisciplinary team and her plan of care will be revised as indicated. Nursing staff will be re-educated on implementation of non- pharmacological interventions prior to medication as an adjunct to pain management.		

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F 309	<p>Continued From page 24</p> <p>services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain residents' highest level of well-being for four of 25 residents in the survey sample, Residents #8, #9 #10 and #13.</p> <ol style="list-style-type: none"> <li>1. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident #8.</li> <li>2. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident #9.</li> <li>3. The facility staff failed to administer Clonidine (1) as ordered by the physician when Resident #10's systolic blood pressure was greater than 160.</li> <li>4. The facility staff failed to obtain Resident #13's blood pressures as ordered by the physician prior to the administration of the medication Norvasc (used to treat high blood pressure (2)) from 3/9/17 through 3/20/17.</li> </ol> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The facility staff failed to implement</li> </ol>	F 309	<p>Resident #10's physician was notified that Clonidine order entry did not reflect recordings of blood pressure; the physician reviewed current blood pressure readings in the MAR and PRN Clonidine was discontinued. Nurse entering the original Clonidine order will receive educational coaching on order entry for PRN BP medications.</p> <p>Resident #13's physician was notified of blood pressure results not documented on MAR 3/9/17 thru 3/20/17. The Nurse revising blood pressure monitoring on MAR will receive educational coaching on verifying data entry for parameters/recording box. Nurses administering Norvasc 3/9/17 thru 3/20/17 without following physician order for specific blood parameters will receive educational coaching on reading and following physician's orders.</p>		

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F 309	<p>Continued From page 25</p> <p>non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident #8.</p> <p>Resident # 8 was admitted to the facility on 03/15/16 with diagnoses that included but were not limited to: atrial fibrillation (1), gastroesophageal reflux disease (2), diabetes mellitus (3), arthritis, anxiety (4), depression, respiratory failure (5), dysphagia (6), hypokalemia (7), and retention of urine.</p> <p>Resident #8's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/20/17, coded Resident #8 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 #8 was coded as requiring extensive assistance of one staff member for activities of daily living.</p> <p>The POS (Physician's Order Sheet) For Resident #8 dated 04/04/17 and electronically signed by the physician on 02/25/17 documented, "Next Review Date: 04/26/2017." The POS further documented, "Oxycodone (8) 5 (five) MG (milligrams). Give 1 (one) tablet via (by) G-Tube [gastrostomy tube (9)] every 6 (six) hours as needed for pain moderate to severe. Order Date: 05/23/2016." "Acetaminophen Liquid (10). Give 650 MG via G-Tube every 6 hours as needed for mild pain. Order Date: 05/23/2016."</p> <p>The care plan for Resident #8 dated 03/24/16 documented, "Focus: Potential for Pain r/t (related to) arthritis, immobility." Under "Interventions/Tasks" it documented, "Assist resident with alternative positioning as a</p>	F 309	<p>2. A review of 24 hour report for past 72 hours will be completed to verify nurses offered and documented non-pharmacological interventions prior to medication administration.</p> <p>A review of residents with orders for blood pressure medications will be completed to verify accuracy of data entry for orders with specific parameters.</p> <p>3. The Nurse Educator or designee will educate licensed nurses on non-pharmacological interventions as an adjunct to medications for pain management, data entry for medications with specific parameters and reading and following physician's orders for monitoring vital signs prior to medications administration. The Nurse Educator or designee will educate UM's and supervisory staff on Center protocol for reviewing new orders to ensure accurate and complete order entry and reviewing 24 hour</p>		

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F 309	Continued From page 26 non-pharmacological intervention. Date Initiated: 03/24/2016."  The MAR (medication administration record) for Resident # 8 dated "January 2017 documented: "Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet via (by) G-Tube [gastrostomy tube] every 6 (six) hours as needed for pain moderate to severe. Order Date: 05/23/2016." "Acetaminophen Liquid. Give 650 MG via G-Tube every 6 hours as needed for mild pain. Order Date: 05/23/2016." Further review of the MAR dated January 2017 revealed acetaminophen liquid was administered on 01/15/17 at 1:12 p.m. and 01/17/17 at 9:04 a.m. and 4:26 p.m. Oxycodone was administered on 01/01/17 at 9:00 p.m., 01/02/17 at 9:05 p.m., 01/03/17 at 9:03 p.m., 01/04/17 at 9:45 p.m., 01/05/17 at 10:01 p.m., 01/06/17 at 12:29 p.m. and 9:08 p.m., 01/07/17 at 9:20 p.m., 01/08/17 at 9:39 p.m., 01/09/17 at 10:43 p.m., 01/10/17 at 10:58 a.m., and 8:49 p.m., 01/11/17 at 10:30 a.m., and 6:35 p.m., 01/12/17 at 9:42 a.m. and 9:07 p.m., 01/13/17 at 9:02 p.m., 01/14/17 at 9:44 a.m., 01/16/17 at 4:13 p.m., 01/17/17 at 9:02 p.m., 01/18/17 at 6:49 p.m., 01/19/17 at 9:18 p.m., 01/21/17 at 9:01 p.m., 01/22/17 at 9:04 p.m., 01/24/17 at 9:01 p.m., 01/25/17 at 8:05 p.m., 01/26/17 at 8:37 p.m., 01/27/17 at 3:10 p.m. and 9:14 p.m., 01/28/17 at 11:50 a.m., 01/29/17 at 9:24 a.m. and 8:42 p.m., 01/30/17 at 3:30 p.m. and 9:38 p.m. and on 01/31/17 8:36 p.m.  The MAR (medication administration record) for Resident # 8 dated "February 2017 documented: "Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet via (by) G-Tube [gastrostomy tube] every 6 (six) hours as needed for pain moderate to severe. Order Date: 05/23/2016."	F 309	report to verify nurses are offering non-pharmacological interventions.  4) 1) The DON and designee will review of resident with blood pressure orders weekly x 4 weeks and monthly x 2 months for residents to verify accuracy of data entry for orders with specific parameters. The DON or designee will review findings and report to QAPI Committee for any further recommendation.  2) The DON and designee will review of 24 hour report for implementation of non- pharmacological interventions weekly x 4 weeks and monthly x 2 months for resident's interventions per resident's individualized plan of care. The DON or designee will review findings and report to QAPI Committee for any further recommendation.  5. Date of compliance: May 10, 2017		

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F 309	<p>Continued From page 27</p> <p>"Acetaminophen Liquid. Give 650 MG via G-Tube every 6 hours as needed for mild pain. Order Date: 05/23/2016."</p> <p>Further review of the MAR dated February 2017 revealed acetaminophen liquid was administered on 02/01/17 at 9:52 a.m. and 02/26/17 at 9:22 a.m. Oxycodone was administered on 02/01/17 at 5:26 p.m., 02/02/17 at 8:44 p.m., 02/05/17 at 11:34 a.m. and 9:38 p.m., 02/07/17 at 5:42 p.m., 02/08/17 at 9:01 p.m., 02/09/17 at 8:31 p.m., 02/10/17 at 9:32 p.m., 02/11/17 at 11:54 a.m., 02/13/17 at 9:51 a.m. and 9:02 p.m., 02/14/17 at 9:42 p.m., 02/15/17 at 4:03 p.m., 02/16/17 at 11:08 a.m. and 8:53 p.m., 02/18/17 at 5:15 p.m., 02/19/17 at 5:25 p.m., 02/21/17 at 9:05 p.m., 02/22/17 at 8:42 p.m., 02/23/17 at 8:40 p.m., 02/26/17 at 2:09 p.m., 02/27/17 at 1:19 p.m. and 7:36 p.m. and on 02/28/17 at 8:11 p.m.</p> <p>The MAR (medication administration record) for Resident # 8 dated "March 2017 documented: "Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet via (by) G-Tube [gastrostomy tube] every 6 (six) hours as needed for pain moderate to severe. Order Date: 05/23/2016."</p> <p>Further review of the MAR dated March 2017 revealed oxycodone administered on 03/01/17 at 9:04 p.m., 03/02/17 at 8:40 p.m., 03/04/17 at 1:50 p.m. and 9:07 p.m., 03/05/17 at 9:02 p.m., 03/06/17 at 9:18 p.m., 03/07/17 at 4:04 p.m., 03/08/17 at 9:24 p.m., 03/09/17 at 8:48 p.m., 03/10/17 at 8:48 p.m., 03/13/17 at 8:59 p.m., 03/14/17 at 5:15 p.m., 03/15/17 at 9:03 p.m., 03/16/17 at 9:02 p.m., 03/17/17 at 4:35 p.m., 03/19/17 at 3:34 p.m., 03/20/17 at 1:00 p.m. and 9:17 p.m. and on 03/28/17 at 10:31 a.m.</p> <p>The MAR (medication administration record) for Resident # 8 dated "April 2017 documented:</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/06/2017
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
(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	<p>Continued From page 28</p> <p>"Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet via (by) G-Tube [gastrostomy tube] every 6 (six) hours as needed for pain moderate to severe. Order Date: 05/23/2016."</p> <p>Further review of the MAR dated April 2017 revealed oxycodone administered on 04/02/17 at 7:51 a.m. and on 04/03/17 at 4:04 p.m.</p> <p>The "Progress Notes" for Resident # 8 dated 01/01/2017 through 04/04/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of acetaminophen liquid and oxycodone.</p> <p>On 4/4/17 at 2:45 p.m. an interview was conducted with RN (registered nurse) # 6. When asked to describe the procedure of administering PRN (as needed) pain medication, RN # 6 stated, "I would ask where the pain is, what type of pain, determine the level of pain on a scale of one to ten, check the physician's orders and when the resident was given the last dose. After administering the medication I would check the resident in an hour to see if the medication was effective." When asked if alternative approaches should be attempted to alleviate a resident's pain before administering pain medication, RN # 6 stated, "I should try other alternatives to pain medication, repositioning, massage or cold/hot packs." When asked where it would be documented that non-pharmacological interventions were attempted, RN # 6 stated, "In the progress notes."</p> <p>On 4/4/17 at 2:55 p.m. an interview was conducted with LPN (licensed practical nurse) # 9. When asked to describe the procedure of administering PRN pain medication, LPN # 9</p>	F 309			

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F 309	<p>Continued From page 29</p> <p>stated, "Assess the resident for pain on a scale one to ten, check the physician's orders and when the resident was given the last dose. After 30 minutes to an hour I would check the resident to see if the medication was effective." When asked if alternative approaches should be attempted to alleviate a resident's pain before administering pain medication, LPN # 9 stated, "I would try repositioning, massage or cold/hot packs." When asked where it would be documented that non-pharmacological interventions were attempted, LPN # 9 stated, "In the progress notes."</p> <p>On 4/5/17 at 3:20 p.m. an interview was conducted with LPN (licensed practical nurse) # 6. When asked to describe the procedure of administering PRN pain medication, LPN # 6 stated, "Assess the resident for pain on a scale one to ten, check the physician's orders and when the resident was given the last dose. Use non-pharmacological interventions. After 30 minutes to an hour I would check the resident to see if the medication was effective and document in the progress notes." LPN # 6 was asked to review the MARs dated January, February, March and April 2017 and the progress notes dated 01/01/17 through 4/4/17 for Resident # 8. When asked to show the documentation that non-pharmacological interventions were attempted prior to the administration of oxycodone and acetaminophen to Resident # 8, LPN # 6 was unable to provide any evidence of the documentation.</p> <p>On 4/5/17 at 4:10 p.m. an interview was conducted with ASM # 2, the director of nursing regarding the implementation and documentation of non-pharmacological interventions prior to the</p>	F 309			

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

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	<p>Continued From page 30</p> <p>administration of PRN pain medication. ASM (administrative staff member) # 2 stated they should try and should be documented in the progress notes.</p> <p>On 4/5/17 at 5:15 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.</p> <p>No further information was provided prior to exit.</p> <p>References:</p> <p>1. A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html">https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html</a>.</p> <p>2. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/gerd.html">https://www.nlm.nih.gov/medlineplus/gerd.html</a>.</p> <p>3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a>.</p> <p>4. Fear. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anxiety.html#summary">https://www.nlm.nih.gov/medlineplus/anxiety.html#summary</a>.</p> <p>5. When not enough oxygen passes from your lungs into your blood. This information was obtained from the website:</p>	F 309			

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

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	Continued From page 31 <a href="https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html">https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html</a> .  6. A swallowing disorder. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html">https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html</a> .  7. Low potassium level is a condition in which the amount of potassium in the blood is lower than normal. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000479.htm">https://medlineplus.gov/ency/article/000479.htm</a> .  8. Used to relieve moderate to severe pain. This information was obtained from the website: <a href="https://medlineplus.gov/druginfo/meds/a682132.html">https://medlineplus.gov/druginfo/meds/a682132.html</a> .  9. A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/002937.htm">https://medlineplus.gov/ency/article/002937.htm</a> .  10. Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/acetaminophen.html">https://www.nlm.nih.gov/medlineplus/acetaminophen.html</a> .	F 309			



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

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/06/2017
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F 309	<p>Continued From page 32 <a href="https://medlineplus.gov/druginfo/meds/a681004.html">https://medlineplus.gov/druginfo/meds/a681004.html</a>.</p> <p>2. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 9.</p> <p>Resident # 9 was readmitted to the facility on 04/14/14 with diagnoses that included but were not limited to: anemia (1), hypertension (2), diabetes mellitus (3), dementia (4), anxiety (5), cerebral ataxia (6), and depression.</p> <p>Resident # 9's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/12/17, coded Resident # 9 as scoring a six on the brief interview for mental status (BIMS) of a score of 0 - 15, six being severely impaired of cognition for making daily decisions. Resident # 9 was coded as requiring extensive assistance of one staff member for activities of daily living.</p> <p>The POS (Physician's Order Sheet) For Resident # 9 dated 04/05/17 and electronically signed by the physician on 02/25/17 documented, "Next Review Date: 04/26/2017." The POS further documented, "Tramadol (7) Tablet 50 MG (milligram). Give 1 (one) tablet by mouth every 8 (eight) hours as needed for moderate pain. Order Start Date: 06/13/2016."</p> <p>The MAR (medication administration record) for Resident # 9 dated "January 2017 documented: "Tramadol Tablet 50 MG (milligram). Give 1</p>	F 309			

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

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	<p>Continued From page 33</p> <p>(one) tablet by mouth every 8 (eight) hours as needed for moderate pain. Order Start Date: 06/13/2016."</p> <p>Further review of the MAR dated January 2017 revealed tramadol was administered on 01/11/17 at 10:14 a.m.</p> <p>The MAR for Resident # 9 dated "February 2017 documented: "Tramadol Tablet 50 MG (milligram). Give 1 (one) tablet by mouth every 8 (eight) hours as needed for moderate pain. Order Start Date: 06/13/2016."</p> <p>Further review of the MAR dated February 2017 revealed tramadol was administered on 02/01/17 at 10:20 p.m., 02/04/17 at 9:28 p.m., 02/07/17 at 5:12 a.m., and on 02/16/17 at 12:16 p.m.</p> <p>The MAR for Resident # 9 dated "March 2017 documented: "Tramadol Tablet 50 MG (milligram). Give 1 (one) tablet by mouth every 8 (eight) hours as needed for moderate pain. Order Start Date: 06/13/2016."</p> <p>Further review of the MAR dated March 2017 revealed tramadol was administered on 03/16/17 at 4:59 p.m. and on 03/29/17 at 2:00 a.m.</p> <p>The "Progress Notes" for Resident # 9 dated 01/11/2017 through 03/29/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of tramadol.</p> <p>On 4/4/17 at 2:45 p.m. an interview was conducted with RN (registered nurse) # 6. When asked to describe the procedure of administering PRN (as needed) pain medication, RN # 6 stated, "I would ask where the pain is, what type of pain,</p>	F 309			

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

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	<p>Continued From page 34</p> <p>determine the level of pain on a scale of one to ten, check the physician's orders and when the resident was given the last dose. After administering the medication I would check the resident in an hour to see if the medication was effective." When asked if alternative approaches should be attempted to alleviate a resident's pain before administering pain medication, RN # 6 stated, "I should try other alternatives to pain medication, repositioning, massage or cold/hot packs." When asked where it would be documented that non-pharmacological interventions were attempted, RN # 6 stated, "In the progress notes."</p> <p>On 4/4/17 at 2:55 p.m. an interview was conducted with LPN (licensed practical nurse) # 9. When asked to describe the procedure of administering PRN pain medication, LPN # 9 stated, "Assess the resident for pain on a scale one to ten, check the physician's orders and when the resident was given the last dose. After 30 minutes to an hour I would check the resident to see if the medication was effective." When asked if alternative approaches should be attempted to alleviate a resident's pain before administering pain medication, LPN # 9 stated, "I would try repositioning, massage or cold/hot packs." When asked where it would be documented that non-pharmacological interventions were attempted, LPN # 9 stated, "In the progress notes."</p> <p>On 4/5/17 at 3:20 p.m. an interview was conducted with LPN (licensed practical nurse) # 6. When asked to describe the procedure of administering PRN pain medication, LPN # 6 stated, "Assess the resident for pain on a scale one to ten, check the physician's orders and</p>	F 309			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2017  
FORM APPROVED  
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F 309	<p>Continued From page 35</p> <p>when the resident was given the last dose. Use non-pharmacological interventions. After 30 minutes to an hour I would check the resident to see if the medication was effective and document in the progress notes." LPN # 6 was asked to review the MARs dated January, February and March 2017 and the progress notes dated 01/11/17 through 03/29/17 for Resident # 9. When asked to show the documentation that non-pharmacological interventions were attempted prior to the administration of tramadol to Resident # 9, LPN # 6 was unable to provide any evidence of the documentation.</p> <p>On 4/5/17 at 4:10 p.m. an interview was conducted with ASM # 2, the director of nursing regarding the implementation and documentation of non-pharmacological interventions prior to the administration of PRN pain medication. ASM (administrative staff member) # 2 stated they should try and should be documented in the progress notes.</p> <p>On 4/5/17 at 5:15 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.</p> <p>No further information was provided prior to exit.</p> <p>References:</p> <p>1. Low iron. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anemia.html">https://www.nlm.nih.gov/medlineplus/anemia.html</a></p> <p>2. High blood pressure. This information was obtained from the website:</p>	F 309			

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

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	Continued From page 36  <a href="https://www.nlm.nih.gov/medlineplus/highbloodpressure.html">https://www.nlm.nih.gov/medlineplus/highbloodpressure.html</a> .  3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a> .  4. A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000739.htm">https://medlineplus.gov/ency/article/000739.htm</a> .  5. Fear. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anxiety.html#summary">https://www.nlm.nih.gov/medlineplus/anxiety.html#summary</a> .  6. A sudden uncoordinated muscle movement due to disease or injury to the cerebellum in the brain. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/001397.htm">https://medlineplus.gov/ency/article/001397.htm</a> .  7. Used to relieve moderate to moderately severe pain. This information was obtained from the website: <a href="https://medlineplus.gov/druginfo/meds/a695011.html">https://medlineplus.gov/druginfo/meds/a695011.html</a> .  3. The facility staff failed to administer Clonidine (1) as ordered by the physician with Resident #10's systolic blood pressure was greater than 160.  Resident #10 was admitted to the facility on 1/30/16 and readmitted on 3/31/16 with	F 309			

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

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/06/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANASSAS HEALTH AND REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8575 RIXLEW LANE</b> <b>MANASSAS, VA 20109</b>		
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F 309	Continued From page 37  diagnoses that included but were not limited to: stroke, high blood pressure, depression and diabetes. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 2/8/17 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as needing minimal assistance from staff for activities of daily living except for dressing which the resident needed moderate staff assistance.  Review of Resident #10's care plan created on 2/12/16 and revised on 3/6/17 documented, "Focus. (Resident #10's initials) has altered cardiovascular status which may impacts (sic) day to day function r/t (related to) hypertension (high blood pressure)...Interventions/Tasks. Administer medications as ordered. Vital Signs per MD (medical doctor) orders and as indicated by s/s/ (signs and symptoms). Notify physician of significant deviations/abnormalities."  Review of the physician's orders dated April 2017 documented, "CloNIDIne HCL (hydrochloride) (indicated in the treatment of hypertension (1)) Tablet 0.1 MG (milligram) Give 1 tablet by mouth every 12 hours as needed for systolic (top number of blood pressure - when the heart beats while pumping blood (2)) b/p (blood pressure) greater than 160. Start Date. 11/15/2016."  Review of the April 2017 MAR (medication administration record) documented, "CloNIDIne HCL Tablet 0.1 MG (milligram) Give 1 tablet by mouth every 12 hours as needed for systolic b/p (blood pressure) greater than 160. Start Date. 11/15/2016." Under each day of the month there	F 309			

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

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/06/2017
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F 309	<p>Continued From page 38</p> <p>were two boxes. One box was titled, "BP (blood pressure)" and the other box was titled "PRN (as needed)." There was no documentation evidenced of the blood pressure results or if the medication was administered.</p> <p>Review of Resident #10's blood pressure summary record documented that blood pressures were taken once a week. A blood pressure of 171/68 on 12/8/16 was documented. Review of the December 2016 MAR did not evidence documentation of the blood pressure or that the Clonidine had been administered.</p> <p>Further review of the blood pressure summary record documented a blood pressure of 166/77 on 11/19/16 was documented. A review of the November 2016 MAR did not evidence documentation of the blood pressure or that the Clonidine was administered.</p> <p>Review of the December 2016 and November 2016 did not evidence documentation regarding the resident's blood pressures or the administration of Clonidine.</p> <p>A telephone interview was conducted on 4/5/17 at 12:15 p.m. with RN (registered nurse) #8, a nurse who cared for the resident. When asked about the process staff follows when a physician orders blood pressure parameters for a medication, RN #8 stated, "You would take the blood pressure and if the blood pressure was over 160 you would give it." When asked if there was any time that the blood pressures would not be checked or the medication would not be given, RN #8 stated, "There's no reason not to do it." The findings were reviewed with RN #8. RN #8 stated, "That's bad. That's a problem. I'm assuming he's one of</p>	F 309			

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F 309	<p>Continued From page 39</p> <p>the patients that gets his BP checked once a week." When asked if that superseded the doctor's order, RN #8 stated, "No, I'm so sorry."</p> <p>An interview was conducted on 4/5/17 at 1:10 p.m. with RN (registered nurse) #5, the interim unit manager. When asked about the process staff follows for physician ordered blood pressure parameters on a medications, RN #5 stated, "The nurse would check the blood pressures. If the blood pressure was too high they would give the medication." When asked if the nurse would document the blood pressures, RN #5 stated, "It would show up in the vital signs (the summary report), but when giving medication with a BP parameter, a spot for the BP comes up (on the MAR)." When asked if it was important to manage Resident #10's blood pressure, RN #5 stated, "If his BP is high it needs to come down. We don't want him to suffer any ill effects like a stroke." RN #5 was made aware of the findings at that time.</p> <p>An interview was conducted on 4/5/17 at 1:25 p.m. with RN #6, the resident's nurse. When asked about the process staff follows for physician ordered blood pressure parameters, RN #6 stated, "You check the BP first. If it's above the parameter the medication should be given." When RN #6 reviewed Resident #10's blood pressure for 12/8/16, she stated, "It should have been given." When asked if there was any reason why the medication should not be given, RN #6 stated, "No."</p> <p>An interview was conducted with ASM (administrative staff member) #2, the director of nursing. The physician's order was reviewed. When asked about the process staff follow for</p>	F 309			



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

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	Continued From page 40  physician ordered parameters for a medication, ASM #2 stated, "We should see a twice a day BP. If we obtain a BP greater than 160 we should administer the Clonidine as ordered." When asked if she expected staff to follow the order, ASM #2 stated, "Yes." A request for a policy on following doctor's orders was made at that time. On 4/5/17 at 4:15 p.m. ASM #2 stated there was no policy on following doctor's orders that staff followed nursing standard practice. When asked what nursing standards the facility used, ASM #2 stated, "Lippincott." On 4/5/17 at 5:15 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.  (1) Clonidine -- Clonidine hydrochloride is indicated in the treatment of hypertension. Clonidine hydrochloride may be employed alone or concomitantly with other antihypertensive agents. This information was obtained from: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=438dece9-95d4-40f2-84b4-9e2c6d88e760">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=438dece9-95d4-40f2-84b4-9e2c6d88e760</a>  (2) Systolic blood pressure- This information was obtained from the website: <a href="https://www.nhlbi.nih.gov/health/health-topics/topics/hbp/">https://www.nhlbi.nih.gov/health/health-topics/topics/hbp/</a>  4. The facility staff failed to obtain Resident #13's blood pressures as ordered by the physician prior to the administration of the medication Norvasc (used to treat high blood pressure (2)) from	F 309			

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

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	Continued From page 41 3/9/17 through 3/20/17.  Resident #13 was admitted to the facility on 9/16/10 with diagnoses that included but were not limited to: dementia, stroke, dysphagia (speech impairment (1)), contractures, high blood pressure and history of falling.  The most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 3/8/17, coded the resident as having both short and long term memory difficulties and being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living.  The physician order dated, 8/16/16, documented, "Norvasc (used to treat high blood pressure (2)) 10 MG (milligrams); Give 1 tablet by mouth in the morning related to ESSENTIAL (PRIMARY) HYPERTENSION (high blood pressure). Hold for SBP (systolic blood pressure) < (less than) 100."  The MAR (medication administration record) for March 2017 documented, "Norvasc 10 MG; Give 1 tablet by mouth in the morning related to ESSENTIAL (PRIMARY) HYPERTENSION. Hold for SBP < 100." The MAR documented the resident received the medication from 3/1/17 through 3/20/17. The blood pressure was documented on 3/1/17 through 3/8/17. There were no blood pressures documented from 3/9/17 through 3/20/17.  On 3/20/17 the physician changed to order to, "Norvasc 10 MG; Give 1 tablet by mouth in the morning related to ESSENTIAL (PRIMARY)	F 309			

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F 309	<p>Continued From page 42</p> <p>HYPERTENSION." There were no parameters with the new physician order.</p> <p>The comprehensive care plan dated, 3/22/17 documented in part, "Focus: (Resident #13) is at risk for complications r/t (related to) Cerebrovascular Disease (stroke)." The "Interventions" documented in part, "Give medications as ordered by the physician. Observe for side effects and effectiveness. Vital signs as ordered/facility protocol. Document and advise physician of abnormal findings as needed."</p> <p>On 4/5/17 at 10:15 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to review Resident #13's Norvasc order prior to 3/20/17. LPN #2 was asked what a nurse is expected to do when they see a physician order like the Norvasc order shown to her. LPN #2 stated, "You have to take the blood pressure before you give the medicine and if the blood pressure (systolic) is less than 100 you hold the medication, call the doctor and call the RP (responsible party)." When shown Resident #13's MAR where no blood pressures were documented from 3/9/17 through 3/20/17, LPN #2 stated, "The doctors and the DON (director of nursing) had a meeting to take the parameters off if the resident was stable." LPN #2 was asked why the order was changed and if the order was still valid if the doctor had not changed it prior to 3/20/17. LPN #2 stated, "I don't know. That's all I can tell you about that."</p> <p>On 4/5/17 at 10:24 a.m., an interview was conducted with LPN #1, the unit manager. LPN #1 was asked to read Resident #13's Norvasc order prior to 3/20/17. LPN #1 was asked what is</p>	F 309			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	Continued From page 43 expected of the nurse's when they have a physician order like the Norvasc order for Resident #13. LPN #1 stated, "The nurse has to take the blood pressure before giving the medication. If the blood pressure is less than 100, then the nurse should hold the medication and notify the physician and RP." The MAR for March 2017 was shown to LPN #1. When asked why there were no blood pressures documented from 3/9/17 through 3/20/17. LPN #1 stated, "I don't know. I would have to research that."  The administrator, direction of nursing, administrative staff member (ASM) #3, the corporate nurse and ASM #4, the corporate RAI (resident assessment instrument) consultant, were made aware of the above findings on 4/5/17 at 5: 24 p.m.  No further information was provided prior to exit.  (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 178.  (2) This information was obtained from the following website: <a href="https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008948/?report=details">https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008948/?report=details</a>	F 309			
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  (b) Skin Integrity -  (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 314	1. The licensed nurse working with Resident #5 on 1/17/17 who failed to document assessment of pressure injury and treatment is no longer employed in the Center. Resident #5's pressure injury remains resolved. A Braden assessment is current with preventative measures are in place.		

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F 314	<p>Continued From page 44</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services for the prevention and treatment of a pressure ulcer for one of 25 residents in the survey sample, Resident #5.</p> <p>The facility staff failed to measure and track a Stage I pressure ulcer* documented as redness in November 2016, and failed to measure, stage and track an open area pressure ulcer identified on 1/17/17 on Resident #5's ADL (activities of daily living) record. On 1/23/17 the wound nurse (LPN [licensed practical nurse] #3) documented an unstagable Pressure sore was present on Resident #5's coccyx, the wound was evaluated by the wound doctor on 1/25/17 and documented as a Stage III pressure ulcer **. The facility staff also failed to complete a quarterly Braden Scale assessment for Resident #5. Resident #5 did not have a Braden scale assessment completed after 7/3/16 until 1/23/17, when a pressure injury* was identified.</p> <p>*Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue</p>	F 314	<p>2. Current residents will have body audits completed to verify skin integrity; any areas identified nurse will verify an appropriate treatment in place per MD orders and documented and notification of MD/RP. Current residents will be reviewed to ensure up to date Braden assessments are completed and preventative measures are in place.</p> <p>3. Nursing staff will be educated by the Nurse Educator or designee on pressure injury prevention, altered skin integrity alerts, assessment of skin integrity, notification of MD/RP and implementation of treatment and Centers protocol on monitoring dashboard for alerts and tracking pressure injuries.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 45</p> <p>usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (1)</p> <p>*Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. (1)</p> <p>**Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (2)</p> <p>The findings include:</p> <p>Resident #5 was admitted to the facility on 3/22/12 with diagnoses that included but were not limited to: dementia, schizophrenia, high blood</p>	F 314	<p>4. The Don or Designee will randomly audit 5 electronic medical records for documentation of risk for, development of wound treatment/intervention in place weekly x 4 weeks and then Monthly x 2. The DON will review findings and report to QAPI Committee for any further recommendation.</p> <p>5. May 10,2017</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 46</p> <p>pressure, osteoporosis, diabetes, anemia, hypothyroid, anxiety and depression.</p> <p>The most recent MDS (minimum data set assessment) a quarterly assessment, with an assessment reference date of 2/8/17, coded the resident as having both short and long term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #5 was coded as requiring extensive assistance of one staff member for all of her activities of daily living except eating and bathing in which she was totally dependent upon the staff for these activities. The resident was coded as being frequently incontinent of both urine and bladder. In Section M - Skin Conditions, the resident was coded as having one Stage 3 pressure area that measured 0.4 cm (centimeters) in length, 0.5 cm in width and 0.2 cm in depth.</p> <p>The MDS prior to the quarterly assessment of 2/8/17 was completed on 11/8/16. In Section M - Skin Condition, it was coded that the resident had a Stage 1*** pressure ulcer.</p> <p>***Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. (3)</p> <p>The "Braden Scale for Predicting Pressure Sore</p>	F 314			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 47</p> <p>Risk Original;" form dated; 7/3/16 documented Resident #5 was a "Moderate Risk" for developing a pressure ulcer.</p> <p>The next completed "Braden Scale for Predicting Pressure Sore Risk Original;" was dated 1/23/17 and documented Resident #5 was a "Low Risk" for developing a pressure ulcer.</p> <p>The Braden Scale for Predicting Pressure Sore Risk is a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level of risk for developing pressure ulcers. It measures functional capabilities of the patient that contribute to either higher intensity and duration of pressure or lower tissue tolerance for pressure. Lower levels of functioning indicate higher levels of risk for pressure ulcer development ...The Braden Scale is a summated rating scale made up of six subscales scored from 1-4 (1 for low level of functioning and 4 for the highest level or no impairment). Total scores range from 6-23 (one subscale is scored with values of 1-3, only). The subscales measure functional capabilities of the patient that contribute to either higher intensity and duration of pressure, or lower tissue tolerance for pressure. A lower Braden Scale Score indicates lower levels of functioning and, therefore, higher levels of risk for pressure ulcer development. (4)</p> <p>A review of "Body Audits" completed for Resident #5's revealed the following documentation:</p> <ul style="list-style-type: none"> <li>- 10/5/16, "Skin integrity intact - yes."</li> <li>- 10/12/16, "Skin integrity intact - No." At the bottom of the form the following was documented, "redness noted to her buttock area."</li> </ul> <p>The rest of the form for the following questions:</p>			F 314			

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/06/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANASSAS HEALTH AND REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8575 RIXLEW LANE</b> <b>MANASSAS, VA 20109</b>		
(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 314	Continued From page 48 "Are any areas new? Physician notified and Responsible party notified..."was blank. - 10/19/16, "Skin integrity intact - yes." At the bottom of the form the following was documented: "Weekly skin assessment done no new skin issue noted." - 10/26/16, "Skin integrity intact - yes." - 11/2/16 documented, "Skin integrity intact - No." At the bottom of the form the following was documented: "weekly skin assessment done, slight redness noted on buttocks area, protective cream applied, TARP (turn and reposition Q (every) 2 hrs. (hours) maintained." - 11/9/16, "Skin integrity intact - yes." - 11/17/16, "Skin integrity intact - yes." - 11/26/16, "Skin integrity intact - yes." - 12/3/16, "Skin integrity intact - yes." - 12/11/16, "Skin integrity intact - yes." - 12/18/16, "Skin integrity intact - yes." - 12/25/16, "Skin integrity intact - yes." - 1/1/17, "Skin integrity intact - yes." - 1/8/17, "Skin integrity intact - no." At the bottom of the form the following was documented: "Weekly skin assessment done no new skin issue noted." There was no further documentation on the form. - 1/15/17, "Skin integrity intact - yes." - 1/19/17 documented, "Skin integrity intact - yes." At the bottom of the form the following was documented: "Weekly skin assessment done no new skin issue." - 1/23/17, "Skin integrity intact - no." At the bottom of the form the following was documented: Coccyx unstageable pressure injury**** 1 cm x (by) 1.5 cm. x 0.2 cm, 90% eschar, 10% slough, no drainage, no odor, edges defined, surrounding area no redness, no c/o (complaints of) pain, skin dry warm, fragile."	F 314			

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F 314	<p>Continued From page 49</p> <p>****Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. (5)</p> <p>A review of the nurse's notes revealed the following documented entries:</p> <ul style="list-style-type: none"> <li>- 10/4/16 at 8:20 p.m. "Redness noted to her buttock area cream applied aid was instructed to TARP (turn and reposition) q (every) 2 (hours) son notified via phone, MD (medical doctor) notified will have wound nurse evaluate tomorrow."</li> </ul> <p>There was no further documentation in the nurse's notes related to this area of redness.</p> <p>The next nurse's note related to Resident #5's skin was dated 1/23/17 at 6:52 a.m. The note documented, "Resident noted with an open area in buttocks which measures 1.8 cm X 2 cm. No bleeding or drainage noted on site. No s/s (signs or symptoms) of infection noted. Area clean with nss (normal saline solution), pat dry and foam dressing applied. MD and RP (responsible party) notified. New order for wound consult received." This was written by LPN (licensed practical nurse) #2.</p> <p>The next note on 1/23/17 at 6:15 p.m. was documented by the wound nurse, LPN #3. The note documented, "This nurse was notified of an open area to residents coccyx, upon assessment,</p>	F 314			

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F 314	Continued From page 50  Coccyx unstageable pressure injury 1 cm X 1.5 cm X 0.2 cm (width times length time depth), 90% eschar (necrotic or black tissue) 10% yellow slough, no drainage, no odor, edges defined, surrounding area no redness, no c/o (complaint of) pain. Body audit done with no further issues noted. MD notified. N.O. (new order) Santyl (Santyl is a sterile enzymatic debriding ointment used to that has a unique ability to digest collagen in necrotic tissue (6)) and foam Q (every) shift, air mattress. Wound cleaned and dressed, RP notified, braden (sic) reassessed; 16 low risk, therapy and RD (registered dietician) screen requested."  The "Pressure Ulcer Report" for Resident #5 dated 1/23/17, documented, "Coccyx unstageable pressure injury 1 cm x 1.5.cm x 0.2 cm, 90% eschar, 10% yellow slough, no drainage, no odor, edges defined, surrounding area no redness, no c/o pain. "Description of healing" - "New" was highlighted. The physician and responsible party were notified on 1/23/17 at 1:00 p.m.  The Wound Consultant Report, dated 1/25/17, documented in part, "Stage 3 Pressure Wound Coccyx. Wound size - 0.7 x 0.5 x 0.3cm. Granulation Tissue: 90% 10 % slough."  The comprehensive care plan for Resident #5 dated, 3/27/12 with a revision on 12/5/16, documented in part the following: " Focus: (Resident #5) has a potential for pressure ulcer development r/t (related to) incontinence." The "Interventions/Tasks" documented in part, "3/27/12 and a revised on date of 12/5/16 - Encourage to turn/reposition at least every 2 hours as tolerated, more often as needed or requested. Follow facility policies and protocols	F 314			

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F 314	<p>Continued From page 51</p> <p>for the preventions and treatment of skin breakdown. 7/21/15 - revised on 12/5/16 - Report to MD PRN (as needed) changes in skin status: appearance, color, wound healing, s/sx (signs and symptoms) of infection, wound size (length X (times) width X depth) stage."</p> <p>Resident #5's TAR (treatment administration record) for January 2017 documented in part, "Zinc Oxide (a topical cream used to protect skin from being irritated and wet caused by diaper use (7)) cream to left buttock for preventative measures." The order was dated, 10/5/16. It was documented as having been administered every day in January 2017. The January 2017 TAR also documented initiation of the physician order on 1/23/17 for: "Santyl Ointment apply to coccyx topically every day shift for wound management. Clean coccyx with SS (saline solution) apply Santyl, cover with foam. Change Q day and PRN." This was documented as having been administered from 1/23/17 through the end of the month. The TAR for January 2017 also documented, "Air mattress, check function Q shift every shift." This order was dated 1/26/17.</p> <p>Resident #5's ADL (activity of daily living) record for January 2017 documented in part on 1/3/17 and 1/17/17, an "oa" indicating an open area and "bu" indicating buttocks. A "Y" indicating, 'yes' the nurse was notified on each of these dates.</p> <p>An interview was conducted with CNA (certified nursing assistant) #1 on 4/5/17 at 10:11 a.m. When asked how often CNAs look at resident's skin, CNA #1 stated, "I look (at the residents skin) during morning care, every two hours when I change them and during their showers." When asked about the process followed if a new open</p>	F 314			

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F 314	<p>Continued From page 52</p> <p>area is observed, CNA #1 stated, "I call the nurse." When asked what she does if she observed an area with redness, CNA #1 stated, "We have a barrier cream we use and I'd apply that."</p> <p>On 4/5/17 at 10:15 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the nurse that documented the open area on Resident #5's coccyx on 1/23/17. LPN #2 was asked about skin assessments for residents. LPN #2 stated, "I check them (resident's skin) on their shower days, twice a week and as needed." LPN #2 was then asked to read her nurse's note dated 1/23/17. When asked to describe the area she found on Resident #5's coccyx on 1/23/17, LPN #2 stated, "It was an open area, round. At first I thought it was shearing. I notified the wound nurse." When asked what interventions were in place for Resident #5, prior to the pressure injury found on 1/23/17, LPN #2 stated, "We had incontinent cream in place. We would get her up before breakfast and ensure she went back to bed in the afternoon to get a rest, off of her bottom. Then we get her up for her dinner meal."</p> <p>An interview was conducted with LPN #1, the unit manager, on 4/5/17 at 10:28 a.m. When asked to explain the pressure ulcer found on Resident #5's coccyx on 1/23/17, LPN #1 stated, "I'd have to investigate that one, I will have to look at the reports and get back with you."</p> <p>An interview was conducted with LPN #3, the wound nurse; on 4/5/17 at 10:51 a.m. LPN #3 was asked to read her note dated 1/23/17 at 6:15 p.m. When asked who found the open area on Resident #5's coccyx, LPN #3 stated, the name of LPN #2. LPN #3 was asked to describe the</p>	F 314			

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F 314	<p>Continued From page 53</p> <p>wound she documented in her 1/23/17 note, "LPN #3 stated, "It was an unstageable coccyx wound with 90% eschar - black and 10% yellow slough." When asked if she was aware of any other areas prior to 1/23/17, LPN #3 stated, "No." When asked if it was unusual to find a pressure sore at an unstageable stage, LPN #3 stated, "It's very unusual. It doesn't happen often." LPN #3 stated, "She (Resident #5) had been sitting in her wheelchair too long. We got it better, it healed quickly." When asked what interventions were in place prior to the pressure sore being found on 1/23/17, LPN #3 stated, "We had a cushion in her wheelchair, a pressure reducing mattress." When asked if a pressure reducing mattress is the standard mattress at this facility, LPN #3 stated, "Yes, it is." LPN #3 stated, "We used barrier cream." When asked if a CNA caring for Resident #5 should have observed Resident #5's coccyx pressure area before it was found with 90% eschar on 1/23/17, LPN #3 stated, "I would hope so?" LPN #3 was asked how often the Braden Scale assessments are completed for residents, and who completed them. LPN #3 stated, "The nurses do. I have to double check on that (the frequency of the assessments) so I don't tell you wrong." LPN #3 returned at 11:28 a.m. and stated, "The Braden Scale (assessment) is done quarterly."</p> <p>On 4/5/17 at 11:30 a.m. LPN #1, the unit manager, returned and stated, "I don't know how it happened (the pressure sore on Resident #5's coccyx) it just appeared." LPN #1 was asked if staff should identify a pressure sore before it has eschar present in the wound, LPN #1 stated, "I would think so."</p> <p>On 4/5/17 at 11:50 a.m. the administrator and</p>	F 314			

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F 314	<p>Continued From page 54</p> <p>director of nursing were informed of the above concerns.</p> <p>On 4/5/17 at 2:25 p.m. an interview was conducted with administrative staff member (ASM) #2, the director of nursing and LPN #3, the wound nurse. ASM #2 stated, "I was not the DON (director of nursing) at that time, I was the assistant director of nursing. In the clinical meeting on 1/23/17 we, the team, were notified of an open area (on Resident #5). LPN #3 is part of the clinical meeting. After the meeting, myself (ASM #2), (LPN #3) and (LPN #1) went to look at the wound. I (ASM #2) saw no black tissue in the wound bed." When asked if she, ASM #2 was certified in wound care, ASM #2 stated, "No, I defer to (LPN #3)." At this time, LPN #3 was asked how long she's been a wound nurse; LPN #3 stated she had been a wound nurse for eight years. When asked if she was certified in wound care, LPN #3 stated, "I wasn't at the time of this wound but I am now." LPN #3 stated, "After you brought this to our attention, I went back and looked at the pressure ulcer investigation. I read my investigation. I made a mistake in my notes." ASM #2 stated, "I feel this wound was not present the day before because of no documentation on the ADLs (activities of daily living) and no identification of any new areas. We were applying barrier cream to the left buttock. The area was on the coccyx. If the wound was present, I would have expected earlier identification."</p> <p>LPN #3 was asked why she documented her note on 1/23/17 if she was now stating it was inaccurate, LPN #3 stated, "I made a mistake. Now that I went through my certification course, I can see I made a mistake. Since my course, I</p>	F 314			

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F 314	Continued From page 55  know better." When asked if she could see the wound bed, LPN #3 stated, "What I think I saw where the edges (of the wound) rolled up on itself. That's where the darkness was, the top of the rolled part of the edges." LPN #3 was again asked what the wound bed looked like. LPN #3 stated, "Pinkish, red." LPN #3 stated, "This was an oversight on my part." The wound care specialist notes were reviewed with LPN #3. The wound doctor documented the wound was a stage 3 pressure injury. LPN #3 stated, "I realized after my training my mistake. I wouldn't have gone back to review this as the wound healed on 3/22/17." When asked if she went back, after her training, to review her wounds, LPN #3 stated, "No the wound was closed." LPN #3 stated, "After this was brought to my attention, I read the doctor's notes, and reread my notes. I made a mistake in my documentation."  ASM #2 stated, "(LPN #3) doesn't go back and reread her notes because this wound was resolving and eventually healed. I saw the wound with my own eyes and didn't see any black tissue; I had to have her explain it to me." When asked how many wounds were in house at the time of this wound, ASM #2 stated, "We had 60 total wounds, not patients and that included surgical wounds, skin tears and such."  LPN #3 was asked what stage Resident #5's coccyx Pressure sore was, if it was not unstagabel as documented in her note dated 1/23/17. LPN #3 stated, "It was a shearing or a stage 2 with rolled edges and darkness."  A call was placed to the wound doctor ASM #5 and a message was left, on 4/5/17 at 4:22 p.m.	F 314			

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F 314	Continued From page 56  An interview was conducted with ASM #5 on 4/5/17 at 4:55 p.m. ASM #5 was asked if he had reviewed his notes, ASM #5 stated that he had. When asked if he could describe the wound on Resident #5's coccyx that he saw on 1/25/17, ASM #5 stated, "I recall it to be a very small wound in the midline of the buttocks, coccyx area. Per the MDS coding it was a shearing with pressure. It was a superficial area that is under lateral stress." When asked what stage the wound was, ASM #5 stated, "It was a stage 3 wound. That is based on the location and the extent of the depth of the wound when I saw it." When asked if he saw any black eschar, ASM #5 stated, "I don't recall. There may have been some on the lateral aspect where there were non-viable edges." When asked if Santyl is used on non-necrotic tissue, ASM #5 stated, "Absolutely, it helps a lot with the improvement in the edges. If I recall, the edges of this wound were dry so Santyl was appropriate. My knowledge of the edges of this wound, they were curled under and dry. It would have been beneficial to use the Santyl." There was an addendum to the note dated, 1/25/17. This was clarified with the wound doctor. ASM #5 stated, "I had written sacrum and it was actually coccyx. There is not much between the bone and fascia in that area, because of the depth I had to call it a stage 3 pressure injury. If it had just a little bit more depth, I would have had to call it a stage 4."  On 4/5/17 at 5:24 p.m. ASM #1, the administrator, ASM #2, ASM #3, the corporate nurse consultant, and ASM #4, the RAI (resident assessment instrument) consultant, were made aware of the concern.	F 314			

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F 314	<p>Continued From page 57</p> <p>On 4/6/17 at 8:37 a.m. ASM #1, ASM #2 and ASM #3 presented a "Timeline" of documents as listed above and actions the facility took in the prevention and treatment of a pressure ulcer for Resident #5.</p> <p>ASM #2 stated, "In November (2016) the resident was noted to have redness to her buttock. The following interventions were put in place:  dietician review  pressure reduction mattress - verified this is the standard mattress for the facility  turning and repositioning  chair/bed with alternate periods of rest  incontinence care with barrier cream which is the facility protocol  foam cushion to wheelchair</p> <p>When asked where the wound care nurse assessment of the resident on 10/4/17, ASM #2 stated, "I do not have documentation of that. I was not the director of nursing at that time and I am unable to locate anything related to that.</p> <p>The timeline documented the CNA documentation on the ADL record for 1/17/17. Resident #5's ADL (activity of daily living) record for January 2017 documented in part an "OA - open area" on 1/3/17 and 1/17/17, and a "Y" indicating "yes" the nurse was notified on each of these dates. ASM #2 stated, "I interviewed the CNA (#4) who documented this on 1/17/17. She informed me that the open area was in the 'butt crack' and not on the buttock. The CNA documentation does not allow for more descriptive documentation, it just allows buttock area which would have included the coccyx. This CNA stated when I interviewed her, that the next day there was a 'patch' over the area. A foam</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER  <b>MANASSAS HEALTH AND REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8575 RIXLEW LANE</b> <b>MANASSAS, VA 20109</b>		
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F 314	Continued From page 58  dressing is our protocol until the wound nurse assesses the wound." When asked where the nurse documented the assessment of the area prior to placing a wound dressing in place, ASM #2 stated, "There is no documentation by the nurse for this. The nurse who did this is no longer employed at the facility." ASM #2 stated, "When I interviewed the CNA she informed me that this was the same area that they had been applying cream to since 11/4/16." When asked where the wound care nurse assessment of this area was documented, ASM #2 stated, "We were not aware of the open area until 1/23/17. But we did a skin audit on 1/19/17 that said her skin was intact." ASM #2 further stated, "When it is documented in the ADLs by the CNA, it is triggered on our dashboard. The Unit Manager and the wound nurse then go do an observation. Once this was brought to our attention, we look at what's going on with this resident. What can we put in place? We followed our protocol - we evaluated her chair cushion and put a new cushion and air mattress on her bed."  The administrator, ASM #1, stated, "The CNA identified the area. The nurse put a treatment in place. It wasn't until the wound was assessed on 1/23/17 that the position of the wound was clarified. The piece we don't have is the documentation of 1/17/17. We feel it's existed for a long time and we have had a care plan in place."  When asked if a Stage 1 pressure injury is tracked, ASM #2 stated, "Yes, they should be." The timeline documented a physician's note of 10/10/16, documenting, "Buttock ulcer, Stage 1 we will continue treatment plan." When asked where the tracking was, ASM #2 stated, "During	F 314			

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F 314	Continued From page 59 that time frame, we do not have any clinical documentation. We would not have not put anything else in place. We had a mattress, barrier cream, foam cushion and incontinence care. Risk areas were being treated with the interventions we had in place. It's not about a Stage 3, this area was compromised when it opened and new interventions were needed." When asked the process for a body audit, ASM #2 stated, "The resident should be disrobed and the nurse should check any bony prominences, noticing any excoriation and if seen should initiate treatment and should be escalated to (LPN #3, the wound nurse)." When asked how this is communicated with (LPN #3), ASM #2 stated, "Usually it is verbally communicated to her but any new areas should have a nurse's note to correspond to the body audit if something was found." ASM #2 stated, "Is there a process problem, yes. We had a care plan in place we do not feel it is documented as harm to the resident. There is room for process improvement but don't feel this is harm."  On 4/6/17 at 9:35 a.m. a message was left to speak with CNA #4. There was no return call back from her as of exit on 4/6/17.  The facility policy, "Pressure Ulcer Prevention and Care Program" documented in part, "Risk Assessment: The Braden Scale for Predicting Pressure Sore Risk is completed by a licensed nurse - at the time of admission, at each quarterly review, annual re-assessment and upon any significant change in condition....Total body observation will be done on admission, with baths/showers, and when additional risk factors which may contribute to development of pressure ulcers are identified. The total body observation	F 314			

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F 314	Continued From page 60 will be done by the licensed nurse upon initial assessment and when additional risk factors are identified. The CNA will observe the resident's skin when giving the bath/shower. Any areas of concern will be reported to the nurse immediately. The nurse will assess the area of concern and take appropriate actions. Findings will be documented in the nursing initial assessment and in the interdisciplinary notes. When additional risk factors are identified, the findings of the total body observation will be documented in the Interdisciplinary notes. The CNA will document their findings in EMR (electronic medical record)...Early Detection: Early detection of pressure ulcers is the responsibility of all members of the resident care team. The Certified Nursing Assistant (CNA) is in an opportune position to detect possible pressure ulcer development as they provide direct care to the resident on a regular basis. The CNA's have the opportunity to observe the resident's skin many times within a 24 hour period. Examples of times to observe the residents are; when bathing and/or dressing the resident, when turning/positioning the resident; when checking the resident for incontinence, when cleaning the resident after incontinent episodes, or when transferring a resident. Pressure ulcers can develop anywhere there is pressure. The obvious areas include: Sacrum and coccyx...The CNA is to verbally report ALL unusual resident observations/changes to their licensed nurse, including the skin observations listed above, and then document what they report in the EMR on the Body Audit. The licensed nurse will: observe the area/condition reported by the CNA, obtain physician's orders, notify the Responsible Party, provide treatment(s) indicated, document the problem thoroughly in the Interdisciplinary Notes,	F 314			

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FORM APPROVED  
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F 314 Continued From page 61  
include in the 24 hour report, and update the  
resident's Care Plan to reflect the  
treatment/preventative measures that are  
implement."

No further information was provided prior to exit.

(1 - 3) This information was obtained from the  
following website:  
<http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/>  
(4) This information was obtained from the  
following website:  
[https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/LNC\\_BRADEN/](https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/LNC_BRADEN/)  
(5) This information was obtained from the  
following website:  
<http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/>  
(6) This information was obtained from the  
following website:  
<http://www.rxlist.com/santyl-drug.htm>  
(7) This information was obtained from the  
following website:  
<https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012707/>

F 323 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT  
SS=D HAZARDS/SUPERVISION/DEVICES

(d) Accidents.  
The facility must ensure that -

(1) The resident environment remains as free  
from accident hazards as is possible; and

(2) Each resident receives adequate supervision  
and assistance devices to prevent accidents.

F 314

F 323

F 323

1. Resident #9's fall mats  
were placed at bedside  
per resident's plan of  
care. The C.N.A and  
nurse caring for Resident  
#9 will receive  
educational coaching on  
ensuring safety devices  
are in place per resident's  
individualized plan of  
care.

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F 323	Continued From page 62  (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.  (1) Assess the resident for risk of entrapment from bed rails prior to installation.  (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.  (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and clinical record review it was determined that the facility staff failed to ensure fall interventions were implemented for one of 25 residents in the survey sample, Resident #9.  The facility staff failed to place fall mats on the floor when Resident #9 was in bed per the comprehensive plan of care.  The findings include:  Resident # 9 was readmitted to the facility on 04/14/14 with diagnoses that included but were not limited to: anemia (1), hypertension (2), diabetes mellitus (3), dementia (4), anxiety (5), cerebral ataxia (6), and depression.  Resident # 9's most recent MDS (minimum data set), a quarterly assessment with an ARD	F 323	<ol style="list-style-type: none"> <li>2. Round rooms will be conducted to verify residents requiring safety devices are in place according to the resident's individualized plan of care.</li> <li>3. The Nurse Educator or designee will educate nursing staff on ensuring safety devices are in place per resident's individualized plan of care.</li> <li>4. The DON and designee will review safety devices weekly x 4 weeks and monthly x 2 months for residents to verify devices are in place according to the resident individualized plan of care. The DON or designee will review findings and report to QAPI Committee for any further recommendation.</li> <li>5. May 10,2017</li> </ol>		

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FORM APPROVED  
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NAME OF PROVIDER OR SUPPLIER

MANASSAS HEALTH AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

8575 RIXLEW LANE

MANASSAS, VA 20109

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F 323 Continued From page 63

(assessment reference date) of 01/12/17, coded Resident # 9 as scoring a six on the brief interview for mental status (BIMS) of a score of 0 - 15, six being severely impaired of cognition for making daily decisions. Resident # 9 was coded as requiring extensive assistance of one staff member for activities of daily living.

On 04/04/17 at 3:40 p.m. an observation of Resident # 9 revealed she was lying in her bed and the fall mats were folded under the bed.

On 04/04/17 at 4:20 p.m. an observation of Resident # 9 revealed she was lying in her bed and the fall mats were folded under the bed.

On 04/04/17 at 5:00 p.m. an observation of Resident # 9 revealed she was lying in her bed and the fall mats were folded under the bed.

On 04/05/17 at 8:30 a.m. an observation of Resident # 9 revealed she was lying in her bed and the fall mats were folded under the bed.

The care plan for Resident # 9 dated 02/17/2014 with a revision date of 01/25/2017 documented, "(Resident # 9) is at risk for falls r/t (related to) decreased mobility, cognitive impairment impacting ability to understand own physical limitations." Under "Interventions/Tasks" it documented, "Fall safety mats at bedside when in bed."

The facility's "Fall Risk Assessment" for Resident # 9 dated 01/10/2017 documented, "High Risk."

The "Kardex" for Resident # 9 documented, "Fall safety mats at bedside when in bed."

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F 323	<p>Continued From page 64</p> <p>On 4/5/17 at 9:55 a.m. an interview was conducted with CNA (certified nursing assistant) # 1. When asked where she obtained the information regarding safety devices required for residents, CNA # 1 stated, "It's on the Kardex." When asked about safety devices for Resident # 9, CNA # 1 looked up Resident # 9's Kardex on the iPad and stated, "She has fall mats." When informed of the above observations of the fall mat not in place next to Resident # 9's bed when she was lying on the bed, CNA # 1 stated, "It was under the bed. It should be next to the bed."</p> <p>On 4/5/17 at 5:15 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.</p> <p>No further information was provided prior to exit.</p> <p>References:</p> <p>1. Low iron. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anemia.html">https://www.nlm.nih.gov/medlineplus/anemia.html</a></p> <p>2. High blood pressure. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/highbloodpressure.html">https://www.nlm.nih.gov/medlineplus/highbloodpressure.html</a></p> <p>3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a></p> <p>4. A loss of brain function that occurs with certain</p>	F 323			

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FORM APPROVED  
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F 323	Continued From page 65 diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000739.htm">https://medlineplus.gov/ency/article/000739.htm</a> .  5. Fear. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anxiety.html#summary">https://www.nlm.nih.gov/medlineplus/anxiety.html#summary</a> .  6. A sudden uncoordinated muscle movement due to disease or injury to the cerebellum in the brain. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/001397.htm">https://medlineplus.gov/ency/article/001397.htm</a> .	F 323			
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--  (1) In excessive dose (including duplicate drug therapy); or  (2) For excessive duration; or  (3) Without adequate monitoring; or  (4) Without adequate indications for its use; or  (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or  (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329	F 329  1. Resident #13's physician was notified of blood pressure results not documented on MAR 3/9/17 thru 3/20/17. The Nurse revising blood pressure monitoring on MAR will receive educational coaching on verifying data entry for parameters/recording box. Nurses administering Norvasc 3/9/17 thru 3/20/17 without		

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FORM APPROVED  
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F 329 Continued From page 66

483.45(e) Psychotropic Drugs.

Based on a comprehensive assessment of a resident, the facility must ensure that--

(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure the drug regimen for one of 25 residents in the survey sample, (Resident #13), was free of unnecessary medications.

The facility staff failed to obtain the physician ordered blood pressures prior to administering the blood pressure medication Norvasc to Resident #13, from 3/9 through 3/20/17.

The findings include:

Resident #13 was admitted to the facility on 9/16/10 with diagnoses that included but were not limited to: dementia, stroke, dysphagia (speech impairment (1)), contractures, high blood pressure and history of falling.

F 329

following physician order for specific blood parameters will receive educational coaching on reading and following physician's orders.

2. A review of residents with orders for blood pressure medications will be completed to verify accuracy of data entry for orders with specific parameters.

3. The Nurse Educator or designee will educate licensed nurses on data entry for medications with specific parameters and reading and following physician's orders for monitoring vital signs prior to medications administration. The Nurse Educator or designee will educate UM's and supervisory staff on Center protocol for reviewing new orders to ensure accurate and

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 67  The most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 3/8/17, coded the resident as having both short and long term memory difficulties and being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living.  The physician order dated, 8/16/16, documented, "Norvasc (used to treat high blood pressure (2)) 10 MG (milligrams); Give 1 tablet by mouth in the morning related to ESSENTIAL (PRIMARY) HYPERTENSION (high blood pressure). Hold for SBP (systolic blood pressure) < (less than) 100."  The MAR (medication administration record) for March 2017 documented, "Norvasc 10 MG; Give 1 tablet by mouth in the morning related to ESSENTIAL (PRIMARY) HYPERTENSION. Hold for SBP < 100." The MAR documented the resident received the medication from 3/1/17 through 3/20/17. The blood pressure was documented on 3/1/17 through 3/8/17. There were no blood pressures documented from 3/9/17 through 3/20/17.  On 3/20/17 the physician changed to order to, "Norvasc 10 MG; Give 1 tablet by mouth in the morning related to ESSENTIAL (PRIMARY) HYPERTENSION." There were no parameters with the new physician order.  The comprehensive care plan dated, 3/22/17 documented in part, "Focus: (Resident #13) is at risk for complications r/t (related to) Cerebrovascular Disease (stroke)." The	F 329	complete order entry.  4. The DON and designee will review of resident with blood pressure orders weekly x 4 weeks and monthly x 2 months for residents to verify accuracy of data entry for orders with specific parameters. The DON or designee will review findings and report to QAPI Committee for any further recommendation.  5. May 10.2017		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329 Continued From page 68

"Interventions" documented in part, "Give medications as ordered by the physician. Observe for side effects and effectiveness. Vital signs as ordered/facility protocol. Document and advise physician of abnormal findings as needed."

On 4/5/17 at 10:15 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to review Resident #13's Norvasc order prior to 3/20/17. LPN #2 was asked what a nurse is expected to do when they see a physician order like the Norvasc order shown to her. LPN #2 stated, "You have to take the blood pressure before you give the medicine and if the blood pressure (systolic) is less than 100 you hold the medication, call the doctor and call the RP (responsible party)." When shown Resident #13's MAR where no blood pressures were documented from 3/9/17 through 3/20/17, LPN #2 stated, "The doctors and the DON (director of nursing) had a meeting to take the parameters off if the resident was stable." LPN #2 was asked why the order was changed and if the order was still valid if the doctor had not changed it prior to 3/20/17. LPN #2 stated, "I don't know. That's all I can tell you about that."

On 4/5/17 at 10:24 a.m., an interview was conducted with LPN #1, the unit manager. LPN #1 was asked to read Resident #13's Norvasc order prior to 3/20/17. LPN #1 was asked what is expected of the nurse's when they have a physician order like the Norvasc order for Resident #13. LPN #1 stated, "The nurse has to take the blood pressure before giving the medication. If the blood pressure is less than 100, then the nurse should hold the medication and notify the physician and RP." The MAR for

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NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 69 March 2017 was shown to LPN #1. When asked why there were no blood pressures documented from 3/9/17 through 3/20/17. LPN #1 stated, "I don't know. I would have to research that."  The administrator, direction of nursing, administrative staff member (ASM) #3, the corporate nurse and ASM #4, the corporate RAI (resident assessment instrument) consultant, were made aware of the above findings on 4/5/17 at 5: 24 p.m.  No further information was provided prior to exit.  (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 178.  (2) This information was obtained from the following website: <a href="https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008948/?report=details">https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008948/?report=details</a>	F 329			
F 387 SS=E	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT  (c) Frequency of Physician Visits  (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.  (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that	F 387	FTAG 387  1. Physician visit complete for resident #19, Physician visit complete for resident #20, physician visit complete for resident #17, Physician visit complete for resident # 9, physician visit complete for resident #11  2. Current resident in the center are at risk of timely physician visits. A review of last 60 days of physician visits to verify complete and scanned/documentated in EMR  3. Education was provided to the Medical Records		

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F 387	Continued From page 70 the facility staff failed to ensure timely physician visits for five of 25 residents in the survey sample, Resident # 19, Resident #20, Resident #17, Resident #9 and Resident #11.  1. The facility staff failed to ensure that Resident #19 was seen by a physician within 60 days between 4/13/16 and 6/23/16 (a period of 71 days), between 8/28/16 and 12/24/16 (a period of 81 days) and between 12/24/16 and 3/10/17 (a period of 76 days).  2. The facility staff failed to ensure that Resident #20 was seen by a physician within 60 days between 10/24/16 and 1/23/17, a 91 day period.  3. The physician failed to examine Resident #17 from 1/9/17 until 3/27/17 (a period of 77 days).  4. The facility staff failed to ensure physician visits were conducted every 60 days for Resident # 9. The clinical record documented the physician visited Resident #9 on 12/20/16 then not again till 03/08/17, (77 days between visits).  5. The facility staff failed to ensure Resident # 11 was seen by a physician from 12/20/16 to 3/8/17, a total of 77 days.  The findings include;  1. The facility staff failed to ensure that Resident #19 was seen by a physician between 4/13/16 and 6/23/16 (a period of 71 days), between 8/28/16 and 12/24/16 (a period of 81 days) and between 12/24/16 and 3/10/17 (a period of 76 days).  Resident #19 was admitted to the facility on	F 387	Coordinator to ensure Physicians Visits were made timely. Education was provided to the attending physician group on timely physician visits.  4. Don or designee will complete weekly audit x 12 weeks to ensure timely physician visits. Communication with each physician will be made of outstanding visits and visits upcoming. The DON or designee will review findings and report to QAPI Committee for any further recommendations.  5. Date of compliance May 10,2017		

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F 387	<p>Continued From page 71</p> <p>7/15/15 with a readmission date of 9/19/15 with diagnoses that included, but were not limited to, dementia, kidney failure, depression and high blood pressure.</p> <p>Resident #19's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/23/17. Resident #19 was coded on the MDS as having a BIMS (brief interview for mental status) score of three out of 15. The MDS manual documents that a score of three indicates that the resident's cognition is severely impaired.</p> <p>A review of Resident #19's clinical record revealed, in part, that Resident #19 had not been seen by a physician within a 60 day period between 4/13/16 and 6/23/16, 8/28/16 and 12/24/16, and 12/24/16 and 3/10/17.</p> <p>On 4/5/17 at 11:05 a.m. an interview was conducted with OSM (other staff member) #4, the medical records director. OSM #4 was asked how often a physician was required to see the residents. OSM #4 stated, "The physician is required to visit a resident every 30 days for the first three months and then every 60 days following the initial three months." OSM #4 was asked how he assured that the physician visits were timely. OSM #4 stated, "At the beginning of each month I run the report to determine who is due for a visit. If the visit is late I will notify the physician via phone. The physician has a 10 day grace period. We have had some problems but were doing much better this year." OSM #4 was asked to provide evidence that Resident #19 was seen within a 60 day period on the aforementioned dates.</p>	F 387			



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FORM APPROVED  
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F 387	<p>Continued From page 72</p> <p>On 4/5/17 at approximately 4:00 p.m. OSM #4 returned and stated that the physician visits were not done within 60 days on the dates provided for Resident #19.</p> <p>On 4/5/17 at 5:10 p.m. an end of the day meeting was conducted with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and ASM #4 the corporate MDS coordinator. The administrative staff was made aware of the above findings and a policy regarding physician visits was requested.</p> <p>A review of the facility policy titled "Physician Services/Visits" revealed, in part, the following documentation; "FEDERAL AND STATE REGULATIONS: 2. The long-term care resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least every 60 days thereafter. 3. "Must be seen," means that the attending physician must make actual face-to-face contact with the resident. 4. A physician's visit is considered timely if it occurs no later than 10 days after the date the visit was required."</p> <p>No further information was provided prior to the end of the survey process.</p> <p>2. The facility staff failed to ensure that Resident #20 was seen by a physician within 60 days between 10/24/16 and 1/23/17, a 91 day period.</p> <p>Resident #20 was admitted to the facility on 11/1/14 with a readmission on 4/4/15 with diagnoses that included, but not limited to, dementia, atrial fibrillation (an irregular heart</p>	F 387			

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

PRINTED: 04/13/2017  
FORM APPROVED  
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F 387	Continued From page 73 beat), high blood pressure, diabetes and anxiety.  Resident #20's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/11/17. Resident #20 was coded on the MDS as having a BIMS (brief interview for mental status) score of nine out of 15. The MDS manual documents that a score of nine indicates that the resident's cognition is moderately impaired.  A review of Resident #20's clinical record revealed, in part, that Resident #20 had not been seen by a physician within a 60 day period between 10/24/16 and 1/23/17.  On 4/5/17 at 11:05 a.m. an interview was conducted with OSM (other staff member) #4, the medical records director. OSM #4 was asked how often a physician was required to see the residents. OSM #4 stated, "The physician is required to visit a resident every 30 days for the first three months and then every 60 days following the initial three months." OSM #4 was asked how he assured that the physician visits were timely. OSM #4 stated, "At the beginning of each month I run the report to determine who is due for a visit. If the visit is late I will notify the physician via phone. The physician has a 10 day grace period. We have had some problems but were doing much better this year." OSM #4 was asked to provide evidence that Resident #20 was seen within a 60 day period on the aforementioned dates.  On 4/5/17 at approximately 3:25 p.m. OSM #4 returned and stated that the physician visits were not done within 60 days on the dates provided for Resident #20.	F 387			

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PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 387	Continued From page 74  On 4/5/17 at 5:10 p.m. an end of the day meeting was conducted with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and ASM #4 the corporate MDS coordinator. The administrative staff was made aware of the above findings.  3. The physician failed to examine Resident #17 from 1/9/17 until 3/27/17 (a period of 77 days).  Resident #17 was admitted to the facility on 3/7/14. Resident #17's diagnoses included but were not limited to: high cholesterol, high blood pressure and arthritis. Resident #17's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 2/4/17, coded the resident as being cognitively intact.  Review of Resident #17's clinical record failed to reveal the physician examined Resident #17 from 1/9/17 until 3/27/17 (a period of 77 days).  On 4/5/17 at 2:10 p.m., an interview was conducted with OSM (other staff member) #4 (the medical records employee responsible for tracking the physician's visits). OSM #4 stated he has a report he can run and the report documents what physician visits are upcoming and what physician visits are overdue. OSM #4 stated he leaves a copy of the report in each physician's personal bin on the nursing unit. OSM #4 stated he also notifies the physicians in person or via email when visits are overdue. When asked if the physicians respond to his notification, OSM #4 stated, "Not as timely as I wish but yes they do."	F 387			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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F 387	<p>Continued From page 75</p> <p>OSM #4 was asked to provide documentation that Resident #17 was examined by the physician between the dates of 1/9/17 and 3/27/17.</p> <p>On 4/5/17 at 3:25 p.m., OSM #4 stated he checked with the physician and had no further information regarding Resident #17's physician visits.</p> <p>On 4/5/17 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.</p> <p>No further information was presented prior to exit.</p> <p>4. The facility staff failed to ensure physician visits were conducted every 60 days for Resident # 9. The clinical record documented the physician visited Resident #9 on 12/20/16 then not again till 03/08/17, (77 days between visits).</p> <p>Resident # 9 was readmitted to the facility on 04/14/14 with diagnoses that included but were not limited to: anemia (1), hypertension (2), diabetes mellitus (3), dementia (4), anxiety (5), cerebral ataxia (6), and depression.</p> <p>Resident # 9's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/12/17, coded Resident # 9 as scoring a six on the brief interview for mental status (BIMS) of a score of 0 - 15, six being severely impaired of cognition for making daily decisions. Resident # 9 was coded as requiring extensive assistance of one staff</p>	F 387			

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

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 387	<p>Continued From page 76</p> <p>member for activities of daily living.</p> <p>A review of the clinical record revealed the physician visited on 12/20/16 then not again till 03/08/17, 77 days between visits.</p> <p>On 4/5/17 at 11:10 a.m. an interview was conducted with OSM (other staff member) # 4, director of medical records. When asked how often a resident needs to be seen by the physician, OSM # 4 stated, "One time per month for the first three months and every sixty days afterwards." When asked how he ensures the physician sees the residents every sixty days, OSM # 4 stated, "I run a report every month that logs when the physician's notes are due. If the physician is late I notify the physician by email." When asked about the missing physician visit for Resident # 9 between 12/20/16 and 03/08/17, OSM # 4 stated he was unable to locate any documentation.</p> <p>On 4/5/17 at 5:15 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.</p> <p>No further information was provided prior to exit.</p> <p>References:</p> <p>1. Low iron. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anemia.html">https://www.nlm.nih.gov/medlineplus/anemia.html</a></p> <p>2. High blood pressure. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/highbloodpr">https://www.nlm.nih.gov/medlineplus/highbloodpr</a></p>	F 387			

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F 387	Continued From page 77 essure.html.  3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a> .  4. A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000739.htm">https://medlineplus.gov/ency/article/000739.htm</a> .  5. Fear. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anxiety.html#summary">https://www.nlm.nih.gov/medlineplus/anxiety.html#summary</a> .  6. A sudden uncoordinated muscle movement due to disease or injury to the cerebellum in the brain. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/001397.htm">https://medlineplus.gov/ency/article/001397.htm</a> .  5. The facility staff failed to ensure Resident # 11 was seen by a physician from 12/20/16 to 3/8/17, a total of 77 days.  Resident # 11 was admitted to the facility on 6/18/12 with diagnoses that included but were not limited to, anemia, high blood pressure, dementia, depression, chronic obstructive pulmonary disease, and cancer of the pancreas.  Resident # 11's most recent MDS (minimum data set) is a quarterly assessment with an ARD (assessment reference date) of 3/15/17.	F 387			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/06/2017
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F 387	<p>Continued From page 78</p> <p>Resident # 11 was assessed as usually understood by others and usually able to understand others. Resident # 11 was coded as scoring a 2 out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns, indicating the resident was severely cognitively impaired.</p> <p>A review of Resident 11's clinical record revealed progress notes that were dated 12/20/16 and 3/8/17, a total of 77 days between physicians visits. No other physician notes were provided.</p> <p>During an interview on 4/5/17 at 7:55 a.m. with ASM (administrative staff member) # 2, the director of nurses, this concern was revealed and a request was made for any other physician visits, notes that could be found between 12/20/16 and 3/8/17. ASM # 2 was also asked which staff member was responsible for keeping track of physician visits. ASM # 2 stated that it was [name of OSM (other staff member) # 4, the medical records staff member]</p> <p>During an interview on 4/5/17 at 11:10 a.m. with OSM # 4, OSM # 4 was asked how often a physician was required to see a resident in the facility. OSM # 4 stated, "The physician sees the resident every 30 days at the time of admission for three months, then he sees them every 60 days." OSM # 4 was asked how he monitored the physician to ensure that they completed the required visits. OSM #4 stated that he would run a computer report at the beginning of each month the computer program [PCC (point click care)] keeps track and alerts him if the physician visits are late. OSM # 4 stated that he then highlights which are overdue and then sends an email to the physician that is overdue. OSM # 4</p>	F 387			

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F 387	Continued From page 79 mentioned that there is a ten day grace period. OSM # 4 further commented that there have been less overdue visits since last year. OSM # 4 was then asked to review Resident # 11's clinical record to see if he could locate any visits between 12/20/16 and 3/8/17.  During an interview on 4/5/17 at 3:25 p.m. with OSM #4, OSM #4 stated that he could not locate any other documentation that a physician visited Resident # 11 between 12/20/16 and 3/8/17.  During the end of day interview on 4/5/17 at 5:13 p.m. with ASM #1, the administrator, ASM # 2, ASM # 3, the corporate nurse, and ASM # 4, regional RAI (resident assessment instrument) consultant, this concern was again reviewed.  No further information was provided prior to the end of the survey process.	F 387			
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--  (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview,	F 425	F425  1. The medication cart has been checked to verify Resident #16's methadone is available.  2. Any resident has the potential to be affected if the nurse fails to re-order control and bulk medications timely. A review of 72 hour report was done to verify no medications not available for administration. Medication carts will be audited to verify control meds and bulk medications are available for administration.  3. The Nurse Educator or designee will re-educate nurses on process for		

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F 425	<p>Continued From page 80</p> <p>clinical record review and review of facility documentation the facility staff failed to ensure physician ordered medications were available for administration for one of 25 residents in the survey sample, (Resident #16).</p> <p>The facility staff failed to ensure Resident #16's physician ordered methadone (narcotic pain medication (1)) was available for administration on 3/31/17.</p> <p>The findings include:</p> <p>Resident #16 was admitted to the facility on 2/8/17. Resident #16's diagnoses included but were not limited to: multiple sclerosis (2), fibromyalgia (3) and anxiety. Resident #16's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/7/17 coded the resident as cognitively intact scoring 15 out of a possible 15 on the brief interview for mental status. Section J documented Resident #16 received scheduled pain medication and as needed pain medication during the last five days. Section J further documented the resident reported almost constant pain rated as a seven on a scale from zero to ten during the last five days.</p> <p>On 4/4/17 at 5:00 p.m. an interview was conducted with Resident #16. When asked if she would like to discuss any concerns regarding her life at the facility, Resident #16 stated she felt the facility staff would run out of her pain medication if she didn't pay attention to how much of the medication was available.</p> <p>Review of Resident #16's clinical record revealed</p>	F 425	<p>ordering meds from pharmacy.</p> <p>4. The DON or designee will review med cart weekly x 4 weeks then monthly x 2 months for 5 residents to verify medications are available for administration. The DON or designee will review findings and report to QAPI Committee for any further recommendations.</p> <p>5. Date of compliance: May 10, 2017</p>		

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F 425	Continued From page 81 a physician's order dated 2/9/17 for methadone 10 mg (milligrams) - two tablets by mouth every eight hours for pain.  Resident #16's methadone controlled medication reconciliation sheet revealed the resident received methadone on 3/31/17 at 6:00 a.m. but failed to reveal the resident received methadone any other time that day. Resident #16's March 2017 eMAR (electronic medication administration record) documented an order for methadone 10 mg- two tablets by mouth every eight hours for pain to be administered at 6:00 a.m., 2:00 p.m. and 10:00 p.m. The code "9" was documented for 3/31/17 at 2:00 p.m. and 3/31/17 at 10:00 p.m. The eMAR legend documented the code "9" indicated, "9 = Other/See Nurse Notes."  A nurse's note dated 3/31/17 at 4:35 p.m. documented, "Pt. (Patient) is alert and verbally responsive. Took all scheduled medication except Methadone 20 mg. MD (Medical doctor) called for script (prescription), script faxed over to pharmacy. Pt c/o (complained of) right leg pain this shift, repositioned to relieve failed. PRN (as needed) hydromorphone (a narcotic pain medication also known as Dilaudid (4)) 6 mg given twice this shift. ADL (Activities of daily living) provided." A nurse's note dated 3/31/17 at 9:17 p.m. documented, "Methadone HCL (Hydrochloride) Tablet 10 MG; Give 20 mg by mouth every 8 hours for Pain; Medication will be given 4/01/17."  Resident #16's comprehensive care plan initiated on 2/9/17 documented, "Patient at risk for pain r/t (related to) decreased mobility and diagnosis of fibromyalgia...Interventions/Tasks: Administer pain medication as ordered..."	F 425			

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F 425	Continued From page 82  On 4/5/17 at 10:40 a.m., an interview was conducted with RN (registered nurse) #4 (the nurse who documented the nurse's note on 3/31/17 at 4:35 p.m.) RN #4 was shown Resident #16's March 2017 eMAR and 3/31/17 nurses' notes. RN #4 stated she didn't have methadone to administer to Resident #16 on that date so she called the pharmacy. RN #4 stated the pharmacy didn't have any refills left on the resident's methadone prescription so she had to call Resident #16's physician and obtain a prescription to send to the pharmacy. RN #4 stated normally when she has a prescription she can obtain an access code from the pharmacy to obtain the medication from the facility stat (immediate) box but methadone was not in the stat box. RN #4 stated Resident #16 had Dilaudid available to take on 3/31/17 (note-review of the resident's March 2017 eMAR revealed the resident was administered as needed Dilaudid per physician's order on 3/31/17 at 8:17 a.m. and 3/31/17 at 7:09 p.m.) RN #4 was asked what facility process was in place to ensure residents didn't run out of medications that required prescriptions. RN #4 stated this wasn't supposed to happen because the methadone was scheduled and was supposed to be re-ordered. RN #4 stated nurses should check when they complete a narcotic count (a count performed to account for narcotic medications) to see how much of the medication is left and when there are five pills left then nurses should call the pharmacy to see if refills are left on the prescription and if not then nurses should call the physician to obtain a new prescription. RN #4 stated she and the supervisor talked to Resident #16 on 3/31/17 regarding the methadone not being available and	F 425			

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F 425	<p>Continued From page 83</p> <p>the supervisor in-serviced staff. RN #4 stated the as needed Dilaudid administered to Resident #16 on 3/31/17 was effective.</p> <p>On 4/5/17 at 1:20 p.m., another interview was conducted with Resident #16. Resident #16 was asked if she had ever missed any pain medications. Resident #16 stated she had missed two doses of methadone this past week. Resident #16 stated staff told her the medication runs out and didn't provide any further information. When asked how this made her feel, Resident #16 stated, "As a person who has managed my medication for years, I couldn't understand how anyone could let it run out." Further into the conversation, Resident #16 stated she remembered she was told further information. Resident #16 stated staff told her the pharmacy didn't tell the nurse there was a need for a new prescription. Resident #16 stated her medication cards used to tell her when she needed a new prescription. When asked if she received Dilaudid on 3/31/17, Resident #16 stated she did but the Dilaudid didn't completely control her pain. Resident #16 stated the methadone is for chronic pain and Dilaudid is for acute pain so missing one or both medications disrupts the management of her pain.</p> <p>On 4/5/17 at approximately 2:30 p.m., ASM (administrative staff member) #2 (the director of nursing) was asked to provide the education provided to staff regarding the unavailability of Resident #16's methadone on 3/31/17.</p> <p>On 4/5/17 at 4:00 p.m., an interview was conducted with ASM #2. ASM #2 was asked what facility process was in place to ensure residents didn't run out of medications that</p>	F 425			

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F 425	<p>Continued From page 84</p> <p>required prescriptions. ASM #2 stated the narcotic medication cards contained blue "re-order" arrow stickers that pointed to one of the pills on the card to indicate the medication needed to be re-ordered from the pharmacy when a five or seven day supply of medication was left. ASM #2 stated when the nurse administers the pill beside the re-order sticker the nurse should re-order the medication in the computer system. ASM #2 stated the pharmacy sends notification via fax when the refill requires a new prescription and the nurse should obtain a new prescription.</p> <p>On 4/5/17 at 4:50 p.m. ASM #2 presented an in-service attendance form, dated 4/3/17, signed by seven employees that documented, "UNAVAILABLE MEDICATIONS- POLICY: An emergency supply of medications typically used in emergencies and starter doses of antibiotics is maintained in the facility in limited quantities by the pharmacy in portable, sealed containers. PROCEDURE: 1. If the ordered medications are not available, the pharmacist is notified for delivery at next scheduled delivery time or if needed prior to the next scheduled med (medication) pass time, the pharmacy will contact the back-up pharmacy for the medication. A pharmacist is available 24 hours a day by phone. 2. Emergency medications and antibiotic kits are kept in the medication rooms on the nursing units. Unopened boxes are sealed with green seals when delivered from the pharmacy service. 3. A list of emergency and stat box contents is posted so that the information is readily accessible..." Review of the facility emergency and stat box lists revealed methadone was not available in the emergency or stat boxes.</p> <p>On 4/5/17 at 5:15 p.m., ASM #1 (the</p>	F 425			

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F 425	Continued From page 85  administrator) and ASM #2 were made aware of the above findings.  The facility policy titled, "PAIN MANAGEMENT IN THE LONG TERM CARE SETTING" documented, "PURPOSE: To protect a Resident's right to have appropriate assessment and management of pain...5.e. Administer the medications as ordered by the physician on the EsMAR..."  The facility/pharmacy policy titled, "ACQUISITION OF CONTROLLED SUBSTANCES" documented, "C. Reorders- Skilled Nursing Facilities and Medicare certified hospice programs follow routine facility protocol for reordering controlled substances at least four (4) days prior to the medication being exhausted. (1) (Name of pharmacy) will only dispense further supply if there is quantity remaining on the current valid prescription. i. If no quantity remains, (name of pharmacy) will outreach to the prescriber with a request for a valid prescription. The facility will be notified that the prescription cannot be dispensed until a valid prescription is received by the pharmacy..."  No further information was presented prior to exit.  (1) This information was obtained from the website: <a href="https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=1356">https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=1356</a>  (2) "Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages	F 425			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 425	Continued From page 86 between your brain and your body, leading to the symptoms of MS..." This information was obtained from the website: <a href="https://medlineplus.gov/multiplesclerosis.html">https://medlineplus.gov/multiplesclerosis.html</a>  (3) "Fibromyalgia is a disorder that causes muscle pain and fatigue. People with fibromyalgia have "tender points" on the body. Tender points are specific places on the neck, shoulders, back, hips, arms, and legs. These points hurt when pressure is put on them." This information was obtained from the website: <a href="https://medlineplus.gov/fibromyalgia.html">https://medlineplus.gov/fibromyalgia.html</a>  (4) This information was obtained from the website: <a href="https://medlineplus.gov/druginfo/meds/a682013.html">https://medlineplus.gov/druginfo/meds/a682013.h tml</a> (4) This information was obtained from the website: <a href="https://medlineplus.gov/druginfo/meds/a682013.h&lt;br/&gt;tml">https://medlineplus.gov/druginfo/meds/a682013.h tml</a>	F 425			
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  c) Drug Regimen Review  (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:  (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 428	F428  1. Resident #13's physician was notified that pharmacy recommendation to discontinue blood pressure monitoring was not processed accurately. The Nurse who processed the pharmacy recommendation will receive educational coaching on how to process a pharmacy recommendation.		

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F 428	Continued From page 87 (iv) Hypnotic.  (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.  (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.  (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.  (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.  (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. 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 follow through on the	F 428	2. Any resident has the potential to be affected if the nurse fails to process pharmacy recommendations accurately. A review of current residents with pharmacy recommendations for the month of March have been reviewed and verified as being processed completely and accurately.  3. The Nurse Educator or designee will educate UM's and supervisory staff on the Centers protocol for acting upon and processing pharmacy recommendations.  4. The DON or designee will audit 10 resident charts monthly x 3 months to verify pharmacy recommendations was processed completely and accurately. The DON or designee will review		

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NAME OF PROVIDER OR SUPPLIER

MANASSAS HEALTH AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

8575 RIXLEW LANE

MANASSAS, VA 20109

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F 428 Continued From page 88

pharmacy medication regimen review  
recommendations for one of 25 residents in the  
survey sample, Resident # 13.

The pharmacy recommendation done in January  
2017 was not acted upon until March 2017.

The findings include:

Resident #13 was admitted to the facility on  
9/16/10 with diagnoses that included but were not  
limited to: dementia, stroke, dysphagia (speech  
impairment (1)), contractures, and history of  
falling.

The most recent MDS (minimum data set)  
assessment, a quarterly assessment with an  
assessment reference date of 3/8/17, coded the  
resident as having both short and long term  
memory difficulties and as being severely  
impaired to make daily cognitive decisions. The  
resident was coded as requiring extensive  
assistance of one or more staff members for all of  
his activities of daily living.

The clinical record was reviewed. The record  
revealed a "Note to Attending  
Physician/Prescriber" from the contractual  
pharmacy dated, 1/21/17. The pharmacist  
documented, "This resident has had HOLD  
PARAMETERS for both the AMLODIPINE and  
CARVEDILOL order since August 2016. Hold for  
SBP (systolic blood pressure) < (less than) 100.  
In review of the last 3-4 months, he has not had  
any doses held. His SBP ranges between 120 -  
130 regularly. Please review if the Hold  
Parameters for the Amlodipine and Carvedilol  
orders may be discontinued at this time." The  
"Physician/Prescriber Response" documented a

F 428

findings and report to  
QAPI Committee for any  
further recommendations

5. Date of compliance: May  
10, 2017

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 428	<p>Continued From page 89</p> <p>check mark next to "Agree." The form was signed by the physician on 1/23/17.</p> <p>The "Summary Copy of Facility Recommendations for Recommendations Created Between 3/1/17 and 3/29/17" documented, "Resident #13, MRR (medication Regimen Review) date: 3/16/17. As this resident has had overall stable blood pressures, in JANUARY, pharmacy asked the physician to consider discontinuing the Hold parameters associated with BP (blood pressure) Medication Orders. The physician AGREED, per the pharmacy recommendation dated 1/21/17. The NORVASC (AMLODIPINE) order continues to state the hold parameters as part of the order on the MAR (medication administration record). RECOMMEND REMOVING the directions in the ORDER that state to "hold for SBP &lt; 100."</p> <p>An interview was conducted with LPN (licensed practical nurse) #1, the unit manager, on 4/5/17 at 11:30 a.m. The two recommendations from the pharmacist were reviewed with LPN #1. When asked why the January recommendation, that was signed by the physician, not acted upon until after the March pharmacy review, LPN #1 stated, "I don't know, I will have to look into that and get back with you."</p> <p>On 4/5/17 at 1:02 p.m. LPN #1 returned to this surveyor. LPN #1 was asked about the process followed for processing the pharmacist's recommendations. LPN #1 stated, "The pharmacy sends the recommendations to the DON (director of nursing) via email. Then they (the recommendations) are divided up by unit and given to the unit managers or the person the DON designates." When asked why the 1/21/17</p>	F 428			

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F 428	<p>Continued From page 90</p> <p>recommendation for Resident #13 was not acted upon until March 2017, LPN #1 stated, "I can't answer why it wasn't done."</p> <p>An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 4/5/17 at 1:15 p.m. When asked about the process followed for reviewing the monthly pharmacy recommendations, ASM #2 stated, "The pharmacist sends the recommendation to me. I then send them out to the unit managers. The physicians then review them (the recommendations). Now the medical director also reviews them (the recommendations) via the summary report." When shown the recommendations for Resident #13 from January and March 2017, ASM #2 stated, "The nurse responsible was written up for not following through with the recommendations."</p> <p>The facility policy, "Medication Regimen Review Policy," documented in part, "4. A written report of all irregularities and recommendations resulting from the medication regimen review are provided to a facility designee for the Attending Physician, Director of Nursing and Medical Director. a. AT a minimum, the written report will contain the resident's name, relevant drug, and irregularity that was identified. b. Report will be submitted within 72 hours of the actual review...A. For non-Urgent recommendations, the Facility and Attending Physician must address the recommendation(s) in a timely manner that meets the needs of the resident - but no later than their next routine visit to assess the resident - and the Attending Physician should document in the medical record: a. What irregularity has been review, B. What action has been taken to address the issue. C. The pharmacy recommendation</p>	F 428			

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F 428	Continued From page 91 itself can be used as a tool to document in the medical record, or a notation may be made in the EHR (electronic health record)."  The administrator, ASM #2, ASM #3 the corporate nurse, and ASM #4 the regional MDS (minimum data assessment) consultant, were made aware of the above concern on 4/5/17 at 5:24 p.m.  No further information was provided prior to exit.  (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 178.	F 428			
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--  (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient	F 431	F431  1. RN#7 will receive Associate Counseling and education for failing to ensure med cart was locked when unattended. The PPD vials were discarded from Dogwood Unit Medication Room.  2. An inspection of the Centers medication carts, medication rooms and treatment carts will be completed to verify they are locked if unattended. Any variances identified will result in associate counseling. An inspection of the Center's Medication Rooms will be conducted to verify multi- dose vials are dated when opened.  3. The Nurse Educator or designee will educate		

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F 431	<p>Continued From page 92</p> <p>detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to secure medications on one of six medication carts and to label and date medication when opened in one of three facility unit medications rooms, (the Dogwood medication room).</p>			F 431	<p>licensed nurses on their responsibility to ensure med carts, med rooms and treatment carts are locked and all meds are secured and educate on dating multi – dose vials upon opening and expiration dates.</p> <p>4. The UM or designee will round weekly x 4 weeks, then monthly x 2 months to verify med carts, med rooms and treatment carts are locked when unattended; any variances identified will result in associate counseling. The UM or designee will inspect med rooms and med carts weekly x 4 to ensure multi -dose vials are</p>		

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NAME OF PROVIDER OR SUPPLIER

MANASSAS HEALTH AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

8575 RIXLEW LANE  
MANASSAS, VA 20109

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F 431 Continued From page 93

1. The facility staff failed to lock a medication cart prior to entering a resident's room.

2. In the Dogwood unit medication room, the facility staff failed to label an open date on two vials of Aplisol PPD (purified protein derivative) solution (a medication used in the diagnosis of tuberculosis [lung infection]). Per manufacturer's instructions, the medication must be discarded 30 days after being opened.

The findings include:

1. An observation was made on 4/4/17 at 3:55 p.m. of a medication cart outside and to the left of room 106. The cart was unlocked and the drawers were able to be opened with medications available. The outer drawer to the narcotic box was unlocked but the box itself was locked. There was a large ring of keys in the top right drawer. No staff or residents were near the cart at the time.

At 3:59 RN (registered nurse) #7 came out of room 106 and went to the medication cart. RN #7 was made aware that the cart was unlocked. When asked what the keys in the cart opened, RN #7 stated, "I don't know. I always keep my keys with me." RN #7 then took a set of keys out of his uniform top. When asked why the medication cart is locked, RN #7 stated, "To make sure somebody doesn't get into the medications." When asked if the cart had been within his line of sight, RN #7 stated, "No."

An interview was conducted on 4/4/17 at 4:20 p.m. with RN #5, the interim unit manager. When asked what staff did when leaving their

F 431

dated upon opening. The DON or designee will review findings and report to the QAPI Committee for any further recommendations.

5. Date of compliance: May 10, 2017

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F 431	<p>Continued From page 94</p> <p>medication carts, RN #5 stated, "We lock them, make sure there's no medication sitting out and keep the keys with them (staff)." When asked about the keys in the medication cart, RN #5 stated, "Those are the supervisor's key ring, they open the laundry room, beauty shop, janitor's closet." When asked if there was a key for the medication carts or the medication room, RN #5 stated, "No."</p> <p>On 4/5/17 at 4:15 p.m. ASM (administrative staff member) #2, the director of nursing was made aware of the findings.</p> <p>Review of the facility's policy titled, "GENERAL GUIDELINES FOR MEDICATION STORAGE" documented, "POLICY. Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members authorized to administer medications. PROCEDURE. 2. Only licensed nurses, the Consultant Pharmacist, and those authorized to administer medications (e.g. medication aides) are allowed access to medications. Medication rooms, carts and medication supplies are locked or attended by persons with authorized access."</p> <p>No further information was provided prior to exit.</p> <p>"Make sure all medications are in locked containers in a room (eg., a medication room) or are under constant surveillance." Potter and Perry, Fundamentals of Nursing, seventh edition, 2009, p. 703.</p>	F 431			

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F 431	<p>Continued From page 95</p> <p>2. The facility staff failed to label an open date on two vials of Aplisol PPD (purified protein derivative) solution (a medication used in the diagnosis of tuberculosis [lung infection] (1)). Per manufacturer's instructions, the medication must be discarded 30 days after being opened.</p> <p>On 4/5/17 at 10:55 a.m., observation of the dogwood medication room was conducted. The medication refrigerator contained two open vials of PPD solution (one vial approximately one third full and one vial approximately one forth full). No open date was documented on the vials or the boxes that contained the vials. The manufacturer's boxes that contained the vials documented, "Once entered, vial should be discarded after 30 days." At this time an interview was conducted with RN (Registered nurse) #5. RN #5 was asked when the medication expired after being opened. RN #5 read the box that contained one of the vials and stated the box documented the medication was good for 30 days once opened. RN #5 was asked how staff would know how long the vials had been opened and when the medication expired. RN #5 stated the date the vials were opened should have been written on the vials and whoever broke the seal on the vials should have written the open date. RN #5 stated she would discard the vials.</p> <p>The manufacturer's instructions documented, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..."</p> <p>On 4/5/17 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the</p>	F 431			



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F 431	Continued From page 96 above findings.  The facility policy titled, "GENERAL GUIDELINES FOR MEDICATION STORAGE" documented, "POLICY: Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier..."  No further information was provided prior to exit.  (1) This information was obtained from the website: <a href="https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1e91a67c-1694-4523-9548-58f7a8871134">https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1e91a67c-1694-4523-9548-58f7a8871134</a>	F 431			
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS  (a) Infection prevention and control program.  The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);  (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441	1. RN#3 will receive Associate Counseling and education on maintaining appropriate infection control practices during medication pass when securing medication from blister cards or packets. A medication pass observation will be conducted on RN#3 to verify she is adhering to infection control practices. The glove and brief were disposed of properly.		

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F 441 Continued From page 97

- (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
- (ii) When and to whom possible incidents of communicable disease or infections should be reported;
- (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
- (iv) When and how isolation should be used for a resident; including but not limited to:
  - (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
  - (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
- (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
- (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.
- (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.
- (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the

F 441

- 2. Any resident has the potential to be affected if Center staff fail to properly dispose of used items. An inspection of Center shower rooms and resident rooms will be conducted to verify used items have disposed of properly in trash receptacles. Any resident has the potential to be affected if nurse fails to adhere to infection control practices during med administration. Random med pass observation will be conducted to ensure nurses are adhering to infection control practices when administering medications.

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F 441	<p>Continued From page 98 spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow infection control practices during the medication administration observation for one of six residents, (Resident #17); and failed to follow infection control practices in one of two resident shower rooms, the shower room on the Magnolia unit.</p> <p>1. RN (Registered nurse) #3 touched one of Resident #17's pills with her bare hand prior to administering the medication to the resident.</p> <p>2. The facility staff failed to dispose of used gloves and part of an incontinence brief in a sanitary manner in the shower room on the Magnolia unit.</p> <p>The findings include:</p> <p>1. RN (Registered nurse) #3 touched one of Resident #17's pills with her bare hand prior to administering the medication to the resident.</p> <p>Resident #17 was admitted to the facility on 3/7/14. Resident #17's diagnoses included but were not limited to: high cholesterol, high blood pressure and arthritis. Resident #17's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 2/4/17, coded the resident as being</p>	F 441	<p>3. The Nurse Educator or designee will educate Center staff on ensuring that used items are disposed of in trash receptacles and not left on floor. The Nurse Educator will re-educate nurses on infection control practices during medication administration.</p> <p>4. Random rounds will be conducted weekly x 4 weeks, then monthly x 2 months to ensure all used items are disposed of in proper receptacles. Random med pass observation will be conducted weekly x 4 weeks, then monthly x 2 months to ensure nurses are adhering to infection control practices during medication administration. The DON</p>		

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F 441	<p>Continued From page 99</p> <p>cognitively intact.</p> <p>On 4/5/17 at 8:10 a.m., this surveyor observed RN #3 preparing Resident #17's medications. RN #3 popped Resident #17's oxycodone 5 milligram tablet (pain medication (1)) out of a blister card that contained multiple pills into her bare hand and dropped the pill into a medication cup. RN #3 popped all other medications from individual packages over top of and into the medication cup without touching the medications. After preparing the medications, RN #3 administered all medications (including the oxycodone) to Resident #17.</p> <p>On 4/5/17 at 8:45 a.m., an interview was conducted with RN #3. RN #3 was asked if she should touch pills with her bare hands. RN #3 stated, "No." RN #3 was made aware of the above observation of her handling Resident #17's oxycodone with her bare hand. RN #3 provided a demonstration of how she popped the medications utilizing hand motions of popping the medications that were individually packaged over top of and into the medication cup. RN #3 was made aware the oxycodone was in a blister card that contained multiple pills, and this surveyor observed her pop the oxycodone into her bare hand and drop the pill into a medication cup. RN #3 stated, "I don't recall that."</p> <p>On 4/5/17 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.</p> <p>The facility policy titled, "GENERAL GUIDELINES FOR MEDICATION ADMINISTRATION" documented, "POLICY: To administer oral</p>	F 441	<p>or designee will review findings and report to the QAPI Committee for further recommendations.</p> <p>5. Date of compliance: May 10, 2017,</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/06/2017
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
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F 441	<p>Continued From page 100</p> <p>medications in an organized and safe manner...6. Tablets and Capsules- b. Never touch any of the medication with fingers..."</p> <p>No further information was presented prior to exit.</p> <p>(1) This information was obtained from the website: <a href="https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cff1eee3-7c02-4f6c-acc5-1f6dcbab92c0">https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cff1eee3-7c02-4f6c-acc5-1f6dcbab92c0</a></p> <p>2. The facility staff failed to dispose of used gloves and part of an incontinence brief in a sanitary manner in the shower room on the Magnolia unit.</p> <p>On 04/04/17 at approximately 4:15 p.m. an observation of the resident shower room on the Magnolia Unit was conducted with LPN (licensed practical nurse) # 1, the unit manager and OSM (other staff member) # 8, the director of housekeeping. Observation of the resident whirlpool tub revealed a used glove and a piece of synthetic material. When asked to identify the synthetic material in the whirlpool tub LPN # 1 stated, "It's a piece of a brief [adult incontinent brief]." LPN # 1 further stated, "I can't tell if the glove or the material is used." When asked if the piece of the incontinent brief and the glove should have been placed in the tub, LPN # 1 stated, "The aides should have thrown them out." OSM # 8 was asked how often the housekeeping staff cleans the resident shower rooms. OSM # 8 stated, "They are cleaned in the morning and two more times during the day, after their lunch and just before they leave for the day."</p> <p>On 04/05/17 at approximately 2:05 p.m. an</p>	F 441			

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F 441	Continued From page 101 observation of the resident shower room on the Magnolia Unit was conducted with LPN # 1, the unit manager, OSM # 3, the director of maintenance, OSM # 8, the director of housekeeping, and ASM (administrative staff member) # 1, the administrator. Observation of the resident shower room revealed a used glove lying on the floor behind the trash barrel. Everyone agreed the glove should have been place in the trash barrel and not on the floor. OSM # 8 immediately picked up the glove and disposed of it.  On 4/5/17 at 5:15 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.  No further information was provided prior to exit.	F 441			
F 504 SS=D	483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN  (a) Laboratory Services  (2) The facility must-  (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to obtain a physician's order prior to obtaining a laboratory test for one of 25 residents in the survey sample, Resident # 8.	F 504	F504  1. Resident #8's physician was notified that a BMP had been obtained 5/2/16 without a physician's order and an order was obtained to correlate with the BMP results.  2. An audit of current resident charts for past 30 days will be completed to verify lab results correlate with a physician's order.  3. The Nurse Educator or designee will educate licensed staff on the Centers process of verifying lab orders and results.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 504	Continued From page 102  The facility staff failed to obtain a physician's order for a BMP (Basic Metabolic Panel [8]) laboratory test for Resident # 8.  The findings include:  Resident # 8 was admitted to the facility on 03/15/16 with diagnoses that included but were not limited to: atrial fibrillation (1), gastroesophageal reflux disease (2), diabetes mellitus (3), arthritis, anxiety (4), depression, respiratory failure (5), dysphagia (6), hypokalemia (7), and retention of urine.  Resident # 8's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/20/17, coded Resident # 8 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 # 8 was coded as requiring extensive assistance of one staff member for activities of daily living.  A review of the clinical record for Resident # 8 revealed the results of a BMP laboratory test dated 05/02/2016. Further review of the clinical record failed to evidence a physician's order for the BMP.  On 4/4/17 at 11:10 a.m. at approximately 3:00 p. m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about the physician's order for Resident # 8's BMP laboratory test ASM # 2 stated, "We're unable to locate it."  The facility's policy "Laboratory Procedure"	F 504	4. The UM or designee will audit lab results weekly x 4 weeks, then monthly x 2 to verify lab results received have a correlating physician's order. The DON or designee will review findings and report to QAPI committee for further recommendations.  5. Date of compliance: May 10, 2017		

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F 504	Continued From page 103  documented, "Procedure: A. obtain a physician's order for all lab work and write the order on the physician's order sheet."  On 4/5/17 at 5:15 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.  No further information was provided prior to exit.  References:  1. A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html">https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html</a> .  2. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/gerd.html">https://www.nlm.nih.gov/medlineplus/gerd.html</a> .  3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm">https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm</a> .  4. Fear. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/anxiety.html#summary">https://www.nlm.nih.gov/medlineplus/anxiety.html#summary</a> .	F 504			
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	Continued From page 104 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-  (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for three of 25 residents in the survey sample, Resident #1, #6 and #12.	F 514	F514  1. The physician visit note for Resident #1 was obtained from the physician and scanned into the electronic medical record. Resident #6 will be assessed by the UM or designee to determine what non-pharmacological interventions may be appropriate to offer her when she experiencing an increase in anxiety and nurses will be educated on utilization and documentation of non-pharmacological interventions as an adjunct to medications in the management of anxiety.		

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NAME OF PROVIDER OR SUPPLIER

MANASSAS HEALTH AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

8575 RIXLEW LANE

MANASSAS, VA 20109

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F 514 Continued From page 105

1. The facility staff failed to obtain a copy of the physician visit note dated 10/31/16 for Resident #1's clinical record.

2. The facility staff failed to document non-pharmacological interventions prior to administering an anti-anxiety medication to Resident #6.

3. Facility staff failed to document non-pharmacological interventions in the clinical record for Resident #12.

The findings include;

1. The facility staff failed to obtain a copy of the physician visit note dated 10/31/16 for Resident #1's clinical record.

Resident #1 was admitted to the facility on 8/8/14 with diagnoses that included, but were not limited to; dementia, Alzheimer's, depression and anxiety.

A review of Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/8/17 revealed, in part, that Resident #1 was coded on the BIMS (brief interview of mental status) as a one out of a possible score of 15, indicating Resident #1 was significantly cognitively impaired in daily decision making.

A review of Resident #1's clinical record did not reveal any documentation that evidenced that Resident #1 had been seen by a physician between 9/19/16 and 12/5/16, a period of 87 days.

F 514

Resident #12's pain will be assessed to determine what non-pharmacological interventions may be effective in offering her prior to administration of PRN medications and nurses will be educated on the utilization and documentation of non-pharmacological interventions as an adjunct to PRN medications in the management of pain.

2. An audit will be completed to ensure residents have a current physicians visit note documented/scanned into the electronic medical record per Center policy.  
Any resident experiencing pain or anxiety has the potential to be affected if nurses fail to offer non-

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F 514	Continued From page 106  ON 4/5/17 at 11:05 a.m. an interview was conducted with OSM (other staff member) #4, the director of medical records. OSM #4 was asked to describe his process for ensuring that the physician visits were timely and that the physician notes were placed into the resident's clinical record. OSM #4 stated that at the beginning of each month he would run a report to determine which residents were "due" for a physician visit and he would notify the physician accordingly. OSM #4 further stated, "We have had some problems but it is better this year. A request was made of OSM #4 to provide evidence that Resident #1 had been seen by a physician between 9/19/16 and 12/5/16.  On 4/5/17 at 12:00 noon OSM #4 provided a physician note dated 10/31/16. When asked where the physician note was located, OSM #4 stated that it had just been faxed to him after he called the physician's office.  On 4/5/17 at 5:10 p.m. an end of the day meeting was conducted with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and ASM #4 the corporate MDS coordinator. The administrative staff was made aware of the above findings and a policy regarding a complete and accurate record was requested. ASM #3 stated that she did not have a policy regarding maintaining a complete and accurate record.  No further information was provided prior to the end of the survey process.  2. The facility staff failed to document	F 514	pharmacological interventions as an adjunct to PRN medications to manage their pain and or anxiety. A review of progress notes for the past 72 hours will be completed to verify nurses are offering non-pharmacological interventions as an adjunct to PRN medications to manage pain and anxiety. 3. The Nurse Educator or designee will review the Center's process on verifying residents have been seen by a physician and visit note is documented/scanned into EMR per Center policy. The Nurse Educator or designee will educate licensed nurses on the		

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F 514	<p>Continued From page 107</p> <p>non-pharmacological interventions prior to administering an anti-anxiety medication to Resident #6.</p> <p>Resident #6 was admitted to the facility on 6/17/15 with a readmission on 2/18/17 with diagnoses of arthritis, anxiety, bipolar depression, dementia and high blood pressure.</p> <p>Resident #6's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 2/25/17. Resident #6 was coded on the MDS as having a BIMS (brief interview for mental status) score of six out of a possible score of 15, indicating that Resident #6 was severely cognitively impaired with daily decision making.</p> <p>A review of Resident #6's MAR (medication administration record) revealed, in part, that Resident #6 received Xanax (an antianxiety medication [1]) on the following dates and times; 3/4/17 7:15 a.m., 3/5/17 0030 (12:30 a.m.), 3/6/17 9:24 a.m., 3/7/17 1518 (3:18 p.m.), 3/20/17 1630 (4:30 p.m.), 3/21/17 1700 (5:00 p.m.), 3/22/17 1700 (5:00 p.m.), 3/28/17 1738 (5:38 p.m.) and 3/30/17 1533 (3:33 p.m.).</p> <p>A review of Resident #6's clinical record did not reveal any documentation that Resident #6 received non-pharmacological interventions prior to receiving Xanax on the stated dates.</p> <p>A review of Resident #6's comprehensive care plan dated 2/18/17 revealed, in part, the following documentation; "Focus; (Name of Resident #6) is at risk for complication(s) r/t (related to) taking antianxiety and antipsychotic medications. Date Initiated: 6/18/2015. Interventions/Tasks: Utilize</p>	F 514	<p>utilization and documentation of non-pharmacological interventions as an adjunct to PRN medications in the management of pain and anxiety.</p> <p>4. DON or designee will complete weekly audit x 12 weeks to ensure timely physician visits are documented in the electronic medical record. The UM or designee will review 5 charts weekly x 4 week, then monthly x 2 to verify nurses are offering and documenting the utilization of non – pharmacological interventions prior to PRN medications as an adjunct for the management of pain and or anxiety. The DON or designee will review the</p>		

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F 514	<p>Continued From page 108</p> <p>non-pharmacological interventions whenever possible to address symptoms/behaviors."</p> <p>On 4/5/17 at approximately 9:30 a.m. an interview was conducted with LPN (licensed practical nurse) #4, a floor nurse. LPN #4 was asked to describe her process prior to administering a prn (as needed) antianxiety medication to a resident. LPN #4 stated, "If the person is anxious or having abnormal behavior we would administer the medication as ordered." LPN #4 was asked if she would attempt non-pharmacological interventions prior to administering an antianxiety medication. LPN #4 stated, "You do whatever you can to take their (resident's) mind off what is making them anxious. It depends on the person. If it (the distraction) doesn't work then administer the medication as ordered." LPN #4 was asked if she would document the non-pharmacological interventions attempted. LPN #4 stated, "I document the non-pharmacological interventions in the nursing notes."</p> <p>On 4/5/17 at 10:30 a.m. an interview was conducted with LPN #5, a floor nurse. LPN #5 was asked to describe her process prior to administering a prn antianxiety medication to a resident. LPN #5 stated, "If a resident is being anxious / agitated we have activities such as coloring, dance and we play music. We see if the resident is incontinent or hungry. If that doesn't work then we administer the anti-anxiety medication." LPN #5 was asked whether or not she would document the non-pharmacological interventions that she had done. LPN #5 stated, "Whatever I do I write about it in the nurse's notes." LPN #5 was asked to review the documentation for 3/4/17 when she had administered Xanax to Resident #6. LPN #5</p>	F 514	<p>findings and report to the QAPI committee for any further recommendations.</p> <p>5. Date of compliance: May 10, 2017</p>		

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F 514	<p>Continued From page 109</p> <p>stated that she was unable to find any documentation regarding non-pharmacological interventions for 3/4/17.</p> <p>On 4/5/17 at 3:20 p.m. an interview was conducted with LPN #8. LPN #8 was asked to describe her process prior to administering an anti-anxiety medication. LPN #8 stated, "If they (the resident) are anxious / agitated I try to distract the resident and provide activities. IF that doesn't work and the resident continues to be very anxious then I give the anti-anxiety medication." LPN #8 was asked if she documented the non-pharmacological interventions in the resident's clinical record. LPN #8 stated, "Sometimes I document but sometimes I don't. Sometimes I just get busy. I know we are supposed to document what we do and the resident's response." LPN #8 was asked to review the aforementioned dates when Xanax was administered to Resident #6. LPN #8 was asked if she had documented non-pharmacological interventions for any of the dates. LPN #8 stated she had not documented what she had done.</p> <p>On 4/5/17 at approximately 4:30 p.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked whether or not the nursing staff were required to document non-pharmacological interventions when they administered a prn antianxiety medication. ASM #2 stated that the nursing staff "should be documenting the symptoms of anxiety" and what was done by the staff prior to administering the medication.</p> <p>An end of day meeting was conducted on 4/5/17 at 5:10 p.m. with ASM #1, the administrator, ASM</p>	F 514			

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F 514	Continued From page 110  #2, the director of nursing, ASM #3, the corporate nurse, and ASM #4, the regional MDS consultant. The administrative staff was made aware of the above findings. A policy regarding a complete and accurate record was requested. ASM #3 stated that she did not have a policy regarding maintaining a complete and accurate record.  No further information was provided prior to the end of the survey process 5. When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html">https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html</a> .  6. A swallowing disorder. This information was obtained from the website: <a href="https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html">https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html</a> .  7. Low potassium level is a condition in which the amount of potassium in the blood is lower than normal. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/000479.htm">https://medlineplus.gov/ency/article/000479.htm</a> .  8. The basic metabolic panel is a group of blood tests that provides information about your body's metabolism. This information was obtained from the website: <a href="https://medlineplus.gov/ency/article/003462.htm">https://medlineplus.gov/ency/article/003462.htm</a> . 3. The facility staff failed to document non-pharmacological interventions in the clinical record for Resident #12.  Resident #12 was admitted to the facility on 3/2/17 and readmitted on 3/17/17 with diagnoses that included but were not limited to: diabetes,	F 514			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/06/2017
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
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F 514	<p>Continued From page 111</p> <p>anemia, high blood pressure, difficulty swallowing and depression.</p> <p>The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 3/31/17 coded the resident as having an 11 out of 15 on the BIMS (brief interview for mental status indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.</p> <p>Review of the care plan created on 3/3/17 documented, "Focus. Patient has pain or potential for pain as noted upon admission assessment. Interventions/Focus. Assist with alternate positioning and other diversional activities to relieve pain,"</p> <p>Review of the physician's orders dated April 2017 documented, "TraMADol HCL (1) Tablet 50 MG (milligrams) Give 1 tablet by mouth every 8 hours as needed for Pain. Start Date; 3/17/17."</p> <p>Review of the March 2017 MAR (medication administration record) documented, "TraMADol HCL Tablet 50 MG (milligrams) Give 1 tablet by mouth every 8 hours as needed for Pain." It was documented that the Tramadol had been given on 3/20/17, 3/21/17 and 3/24/17.</p> <p>Review of the April 2017 MAR documented, "TraMADol HCL Tablet 50 MG (milligrams) Give 1 tablet by mouth every 8 hours as needed for Pain." It was documented that the Tramadol had been given on 4/4/17.</p> <p>Review of the nurse's notes on 3/20/17, 3/21/17, 3/24/17 and 4/4/17 did not evidence</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER  <b>MANASSAS HEALTH AND REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8575 RIXLEW LANE</b> <b>MANASSAS, VA 20109</b>		
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F 514	<p>Continued From page 112</p> <p>documentation regarding non-pharmacological interventions attempted prior to the administration of Tramadol.</p> <p>An interview was conducted on 4/5/17 at 10:40 a.m. with RN (registered nurse) #4, a nurse who gave Resident #12 the Tramadol. When asked what process staff followed when a resident complained of pain, RN #4 stated, "I ask where their pain is. How they rate it on a scale of one to ten with ten being the highest (level of pain). I ask when it started, what makes it get worse, what helps the pain." When asked what the staff did next, RN #4 stated, "Non-pharmacological interventions I can do them as a nurse. I first do that to alleviate the pain." When asked if this was documented, RN #4 stated, "It should have been in the notes." RN #4 reviewed the nurse's notes and stated she had not documented the non-pharmacological interventions. When asked why staff documented the interventions, RN #4 stated, "For other nurses to have a better idea of what's going on with the patient. When asked if she had tried non pharmacological interventions on Resident #12 prior to administering the Tramadol, RN #4 stated, "I don't remember if I did, I usually do."</p> <p>An interview was conducted on 4/5/17 at 1:00 p.m. with RN #7, a nurse who gave Resident #12 Tramadol. When asked the process staff followed when a resident complained of pain, RN #7 stated, "Ask them where the pain is, what can I to make it feel better and try to reposition (the resident) and if that doesn't help then ask them the pain rating." When asked if this would be documented, RN #7 stated, "In my progress notes." When asked to review the nurse's notes for the day he administered the Tramadol, RN #7</p>	F 514			

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F 514	Continued From page 113 stated, "I don't have a note."  An interview was conducted on 4/5/17 at 4:15 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked if staff were expected to try non-pharmacological interventions prior to administering pain medication, ASM #2 stated yes. When asked if those interventions would be documented, ASM #2 stated, "I would expect to see it inside (the EMAR)." ASM #2 was made aware of the findings at that time.  No further information was obtained prior to exit.  Potter-Perry Fundamentals of Nursing, 6th Edition, page 477 reads: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client 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.  (1) Tramadol -- Tramadol is an opioid analgesic used for the therapy of mild-to-moderate pain. Tramadol overdose can cause acute liver failure. This information was obtained from: <a href="https://livertox.nih.gov/Tramadol.htm">https://livertox.nih.gov/Tramadol.htm</a>	F 514			