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	495217	A. BUILDING _____ B. WING _____	04/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/11/16 through 4/13/16. Corrections are required for compliance with 42CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 155 certified bed facility was 130 at the time of the survey. The survey sample consisted of 21 current Resident Reviews (Residents # 1 through # 21) and four closed record reviews (Residents # 22 through # 25).	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278	It is the practice of this facility to maintain a complete and accurate MDS for our residents. I. A corrected MDs for resident # 6 was completed and submitted on 4/13/16. II. Residents having a completed MDS in the current flu season, who the facility failed to code the influenza status correctly have the potential to be affected by this deficient practice. An audit of MDSs submitted for current residents during the current flu season was conducted to ensure the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamara D. Weiber	NHA	5-10-16

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

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F 278	Continued From page 1 penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for one of 25 residents in the survey sample, Resident #6. The facility staff failed to correctly code Resident #6's influenza status as "not offered" rather than "offered and declined" on the 2/12/16, quarterly MDS assessment. The findings include: Resident #6 was admitted to the facility on 8/18/15 with a readmission on 11/23/15 with diagnoses that included but were not limited to: depression, high blood pressure, dementia and hip fracture. The most recent MDS, a quarterly assessment, with an ARD (assessment reference date) of 2/12/16 coded the resident as a six out of 15 on the brief interview of mental status indicating the resident was severely impaired cognitively. Resident #6 was coded as requiring the assistance of staff for all activities of daily living. In Section O0250 titled Influenza Vaccine it was documented, "C. If influenza vaccine not received, state reason: 4. Offered and declined."	F 278	influenza status was coded correctly. Any errors found were corrected. III. Staff responsible for the accurate completion of the MDS were educated on the correct way to code a patient's influenza status. IV. MDS assessments will be audited prior to submission for the accuracy of the coded influenza status. These audits will occur on each assessment completed for two weeks beginning 4/14/16. Three assessments will be audited for the following three weeks and then random assessments will be audited for the following three weeks to ensure substantial compliance. This compliance will be monitored by the facility's Administrator and reported to the Quality Assurance	

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F 278	Continued From page 2 Review of the clinical record did not evidence documentation Resident #6 or her responsible party declined the vaccine. Review of the nurse's notes from October 2015 to March 2016 did not evidence documentation that Resident #6 or her responsible party declined the vaccine. Review of Resident #6's care plan initiated on 8/19/15 and revised on 12/2/15 did not evidence documentation regarding the influenza vaccine. A request was made to ASM (administrative staff member) #1, the administrator, on 4/12/16 at 1:30 p.m. for a copy of Resident #6's influenza consent. On 4/12/16 at 2:40 p.m. an interview was conducted with RN (registered nurse) #7, an MDS coordinator. When asked what policy they used to complete the MDS, RN #7 stated, "We use the RAI (resident assessment instrument) manual." On 4/12/16 at 2:55 p.m. ASM #1, the administrator, stated, "They can't find the consent." When asked if they could locate any documentation regarding the influenza vaccine for Resident #6, ASM #1 stated that they could not. An interview was conducted on 4/12/16 at 4:30 p.m. with RN (registered nurse) #2, the unit manager. When asked what process staff followed for educating and obtaining the influenza consent, RN #2 stated, "We usually get it on admission, we ask the patient or family if they want it." RN #2 was observed reviewing a form	F 278	Committee. The Committee will determine the need for adjustments to this plan if required. V. 5/28/16	

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titled, "Unit Immunization Tracking Log." RN #2 stated that it was her responsibility to track the residents' influenza vaccine status. The form did not evidence documentation that Resident #6 had been offered the influenza vaccination. When asked how the MDS coordinator would know that a resident had declined the vaccine, RN #2 stated, "They go to the chart and find the consent."

An interview was conducted on 4/12/16 at 4:45 p.m. with RN #5 and 6, the MDS coordinators, regarding the process for completing the influenza section of the MDS assessments. RN #5 stated, "I go to the admission tab but sometimes if I don't see it there I go to the chart and look it up in the chart." RN #6 stated, "We didn't do this MDS but let me look. I see the pneumonia was declined but there's nothing here about the flu."

On 4/13/16 at 7:55 a.m. RN #6, the MDS coordinator provided a copy of Resident #6's tracking form used by the MDS staff to complete the 2/12/16 MDS. In the section titled "FLU VAC (vaccine) 0 (with a line through it indicating not) offered was documented. RN #6 stated, "The MDS person who completed this wrote it was not offered and somehow coded it incorrectly. It (the MDS) is not correct. We couldn't find anything in the record that it (the flu vaccine) was offered."

The findings were shared on 4/13/16 at 8:40 a.m. with ASM #2, the director of nursing.

No further information was provided prior to exit.

F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	

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F 279	Continued From page 4 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan for four of 25 residents in the survey sample, Residents #3, #19, #13 and #16. 1. The facility staff failed to develop a comprehensive care plan for the triggered care areas of visual function and ADL (activities of daily living) function/rehabilitation potential on Resident #3's significant change in status Minimum Data Set (MDS) assessment with an ARD (assessment reference date) of 3/2/16.	F 279	It is the practice of this facility to develop comprehensive care plans for our residents. I. A care plan for visual function was developed for resident # 3 on 4/12/16. A care plan for urinary incontinence was developed for resident #19 on 4/13/16. A care plan for urinary incontinence and indwelling catheter was developed for resident #13 on 4/12/16. A care plan for falls was developed for resident #16 on 4/12/16. II. Residents without comprehensive care plans for triggered areas of the MDS could potentially be affected by this deficient practice. An audit was conducted of MDS assessments completed for the past 60 days to ensure areas triggered were care planned as appropriate.	

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F 279	Continued From page 5 2. The facility staff failed to develop a comprehensive care plan for the triggered care area of urinary incontinence on Resident #19's admission MDS assessment with an ARD of 10/7/15. 3. The facility staff failed to develop a care plan for the triggered area of "Urinary Incontinence and Indwelling Catheter" from the CAA summary on Resident #13's 10/30/15 admission MDS assessment. 4. The facility staff failed to develop a care plan for the triggered area of "Falls" from the CAA summary of Resident #16's 4/4/16 admission MDS assessment. The findings include: 1. The facility staff failed to develop a comprehensive care plan for the triggered care areas of visual function and ADL (activities of daily living) function/rehabilitation potential on Resident #3's significant change in status Minimum Data Set (MDS) assessment with an ARD (assessment reference date) of 3/2/16. Resident #3 was admitted to the facility on 5/30/15 and readmitted on 9/8/15. Resident #3's diagnoses included but were not limited to: *dementia, hypertension (high blood pressure) and an enlarged prostate. Resident #3's most recent MDS, a significant change in status assessment with an ARD of 3/2/16, coded the resident as being cognitively intact. Section B coded Resident #3's vision as being impaired. Section G documented the resident required extensive assistance of two or	F 279	III. Staff responsible for developing comprehensive care plans based on areas triggered by the completion of the MDS were educated on the procedure to following related to the completion of a comprehensive care plan when areas are triggered on the MDS. IV. Completed MDSs will be audited to ensure comprehensive care plans are developed for triggered areas. This audit will occur for each assessment completed for two weeks beginning 4/14/16. The audit will continue for 3 assessments for the following 2 weeks and then random audits will occur for the next 2 weeks to ensure compliance with this plan. The compliance will be monitored by the facility's Administrator and reported to the Quality Assurance Committee. The	

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F 279	Continued From page 6 more staff with bed mobility/transfers and extensive assistance of one staff with locomotion, dressing and eating. Section V "Care Area Assessment (CAA) Summary" documented, "1. Check column A if Care Area is triggered. 2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment in the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (resident assessment instrument) (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan..." An "X" was documented in the "Care Area Triggered" and "Care Planning Decision" columns beside the care areas of "03. Visual Function" and "05. ADL (activities of daily living) Functional/Rehabilitation Potential" indicating the care areas would be care planned. Review of Resident #3's comprehensive care plan created on 5/30/15 failed to reveal documentation regarding visual function or ADL Function/Rehabilitation Potential. On 4/12/16 at 2:32 p.m., an interview was conducted with RN (registered nurse) #6 (the MDS coordinator who had been employed at the facility for approximately one month) and RN #7 (the regional MDS coordinator). RN #6 and RN #7 were shown section V of Resident #3's MDS and asked to show this surveyor where visual function and ADL function were documented on the resident's care plan. RN #7 confirmed visual function and ADL function were not documented on Resident #3's care plan. RN #7 was asked if those areas should have been care planned. RN #7 stated, "If they put yes, they needed to care plan." RN #7 stated MDS staff references the RAI manual when developing care plans based	F 279	Committee will determine the need for adjustments to this plan if required. V. 5/28/16	

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on section V of the MDS.

On 4/12/16 at 5:55 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. A policy regarding care planning based on MDS assessments was requested.

On 4/13/16 at 9:12 a.m., ASM #1 stated the facility did not have the requested policy.

The CMS (Centers for Medicare & Medicaid Services) RAI manual documented the following:

"Coding Instructions for V0200A, CAAs
·Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.
·For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the

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resident's care plan was completed."

*"Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html

2. The facility staff failed to develop a comprehensive care plan for the triggered care area of urinary incontinence on Resident #19's admission MDS assessment with an ARD of 10/7/15.

Resident #19 was admitted to the facility on 9/30/15. Resident #19's diagnoses included but were not limited to: *dementia, hypertension (high blood pressure) and major depressive disorder.

Resident #19's most comprehensive MDS, an admission assessment with an ARD of 10/7/15, coded the resident's cognition as being moderately impaired. Section H coded Resident #19 as frequently incontinent of urine. Section V "Care Area Assessment (CAA) Summary" documented, "1. Check column A if Care Area is triggered. 2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment in the care area. The Care Planning Decision column must be completed

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within 7 days of completing the RAI (resident assessment instrument) (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan..." An "X" was documented in the "Care Area Triggered" and "Care Planning Decision" columns beside the care area of "06. Urinary Incontinence and Indwelling Catheter" indicating the care area would be care planned. Review of Resident #19's comprehensive care plan created on 9/30/15 failed to reveal documentation regarding urinary incontinence.

On 4/13/16 at 8:40 a.m., an interview was conducted with RN (registered nurse) #6 (the MDS coordinator who had been employed at the facility for approximately one month). RN #6 was shown section V of Resident #19's MDS assessment and asked to review the resident's care plan for information regarding urinary incontinence. RN #6 reviewed the care plan and stated, "I don't see it but sometimes they resolve (the care plan area) by mistake." RN #6 reviewed the resolved care plan and stated, "It's not there."

On 4/13/16 at 9:12 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

*"Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." This information was obtained from

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the website:
https://www.nlm.nih.gov/medlineplus/dementia.html

3. The facility staff failed to develop a care plan for the triggered area of "Urinary Incontinence and Indwelling Catheter" from the CAA summary on Resident #13's 10/30/15 admission MDS assessment.

Resident #13 was admitted to the facility on 10/23/15 with the diagnoses of but not limited to dysphagia, cerebral vascular disease, edema, anxiety, high blood pressure, depression, diabetes, and heart disease.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/30/16. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident required extensive care for hygiene, bathing, and dressing; limited assistance for transfers and ambulation; supervision for eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed the most recent comprehensive MDS was an admission MDS assessment with an ARD of 10/30/15. In Section V, Care Area Assessment (CAA) Summary, the resident was triggered for the area of "Urinary Incontinence and Indwelling Catheter" in Column A (Care Area Triggered). In Column B (Care Planning Decision) this was marked with an "x" to indicate this area was to be care planned. A review of the care plan failed to reveal any evidence that urinary incontinence was care planned.

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On 4/12/16 at 3:04 p.m., in an interview with RN #7 (Registered Nurse, the MDS nurse), she stated that it should have been care planned. She stated that the MDS staff that was at the facility at the time was no longer employed at the facility, so she was not able to say why it was not care planned. When asked about a policy for developing a comprehensive care plan, she stated the facility uses the RAI manual (Resident Assessment Instrument).

On 4/12/16 at 5:50 p.m., at the end of day meeting, the Administrator and Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.

Chapter 4 of CMS's (Centers for Medicare and Medicaid Services) RAI Version 3.0 Manual documents the following information: "4.7 The RAI and Care Planning...the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care...The care plan should be revised on an ongoing basis to reflect changes in the resident and the care the resident is receiving..."

4. The facility staff failed to develop a care plan for the triggered area of "Falls" from the CAA summary of Resident #16's 4/4/16 admission

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MDS assessment.

Resident #16 was admitted to the facility on 3/28/16 with the diagnoses of but not limited to; right hip replacement, high blood pressure, and osteomyelitis.

The most recent MDS (Minimum Data Set) was the admission assessment with an ARD (Assessment Reference Date) of 4/4/16. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident required extensive assistance for bathing. hygiene, transfers, ambulation, dressing, and toileting; supervision for eating; and was occasionally incontinent of bowel and bladder.

A review of the clinical record revealed the most recent comprehensive MDS was an admission MDS with an ARD of 10/30/15. In Section V, Care Area Assessment (CAA) Summary, the resident was triggered for the area of "Falls" in Column A (Care Area Triggered). In Column B (Care Planning Decision) this was marked with an "x" to indicate this area was to be care planned. A review of the care plan failed to reveal any evidence that falls was care planned.

On 4/13/16 at 8:05 a.m., in an interview with RN #6 (Registered Nurse, the MDS nurse), she stated that it should have been care planned if it was triggered, and that it was missed. She stated that nursing usually initiates Falls care plans but if they do not, then the MDS staff should pick it up when developing the comprehensive care plan.

On 4/12/16 at 5:50 p.m., at the end of day meeting, the Administrator and Director of

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F 279	Continued From page 13 Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 279		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding	F 334	It is the practice of this facility to offer the influenza vaccine to our residents. I. The flu vaccine was offered to resident #6 on 4/28/16. The vaccine was administered on 4/29/16 II. Residents residing in the facility during the current flu season have the potential to be affected by this deficient practice. An audit of current resident was conducted to ensure the flu vaccine was offered during the flu season beginning October 2015 and that the offering was properly documented. Any resident found to not have been offered will be corrected. III. Licensed nursing staff was educated on the importance of offering the flu vaccine and the process	

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F 334	Continued From page 14 the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. 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 offer the influenza vaccination to one of 25 residents, Resident #6. The facility staff failed to offer Resident #6 the	F 334	to document the offering. IV. The Directory of Nursing will audit new admissions to ensure proper documentation is present to ensure the flu vaccine was offered. This audit will occur for each new admission for the two weeks beginning 4/14/16 then random new admission for the 4 weeks following to ensure substantial compliance. The compliance will be reported to the Quality Assurance Committee. The Committee will determine the need for adjustments to this plan if required. V. 5/28/16	

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influenza vaccination for the 2015-2016 flu season.

The findings include:

Resident #6 was admitted to the facility on 8/18/15 with a readmission on 11/23/15 with diagnoses that included but were not limited to: depression, high blood pressure, dementia and hip fracture.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/12/16 coded the resident as a six out of 15 on the brief interview of mental status indicating the resident was severely impaired cognitively. Resident #6 was coded as requiring the assistance of staff for all activities of daily living. In Section O0250 Influenza Vaccine it was documented, "C. If influenza vaccine not received, state reason: 4. Offered and declined."

Review of the clinical record did not evidence documentation that the resident or her responsible party declined the vaccine.

Review of the nurse's notes from October 2015 to March 2016 did not evidence documentation that the resident or her responsible party declined the vaccine.

Review of Resident #6's care plan initiated on 8/19/15 and revised on 12/2/15 did not evidence documentation regarding the influenza vaccine.

A request was made of ASM (administrative staff member) #1, the administrator, on 4/12/16 at 1:30 p.m. for a copy of Resident #6's influenza consent.

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On 4/12/16 at 2:55 p.m. ASM #1, stated, "They can't find the consent." When asked if they could locate any documentation regarding the influenza vaccine for the resident, ASM #1 stated that they could not.

An interview was conducted on 4/12/16 at 4:30 p.m. with RN (registered nurse) #2, the unit manager, regarding the process staff followed for educating and obtaining consent for the influenza vaccine. RN #2 stated, "We usually get it on admission, we ask the patient or family if they want it." RN #2 was observed reviewing a form titled, "Unit Immunization Tracking Log." RN #2 stated that it was her responsibility to track the residents' influenza vaccine status. The form did not evidence documentation that Resident #6 had been offered the influenza vaccination. RN #2 stated, "I checked the chart and I did not find the flu consent." When asked if she expected to find the consent on the chart, RN #2 stated, "Yes and if not we revisit the topic with the family." When asked who were responsible for obtaining the consent for the influenza vaccination, RN #2 stated, "The nurses, on admission if the resident is alert and oriented, if they're not we ask the family."

An interview was conducted on 4/13/16 at 8:40 a.m. with ASM #2, the director of nursing. When asked what process staff followed for obtaining the influenza vaccination, ASM #2 stated, "Everyone should be screened for the flu. On admission we ask them if they want flu vaccine. It (the importance of the influenza vaccination) should be explained to them. The flu vaccine should be offered to everyone in the building." The findings were shared at that time.

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Review of the facility's policy titled, "Chapter 9: Screening and Immunization" documented in part, "The patient or legal representative is provided the opportunity to refuse immunization. Many elders in long term care setting become ill because of the contagious spread of disease from employees, volunteers and visitors. Elder immune systems are generally more fragile and susceptible to flu."

No further information was provided prior to exit.

If possible, all residents should receive trivalent inactivated influenza vaccine (TIV) annually before influenza season. In the majority of seasons, TIV will become available to long-term care facilities beginning in September, and influenza vaccination should commence as soon as vaccine is available. Informed consent is required to implement a standing order for vaccination, but this does not necessarily mean a signed consent must be present.
In the event that a new patient or resident is admitted after the influenza vaccination program has concluded in the facility, the benefits of vaccination should be discussed, educational materials should be provided, and an opportunity for vaccination should be offered to the new resident as soon as possible after admission to the facility. Since October 2005, the Centers for Medicare and Medicaid Services (CMS) has required nursing homes participating in Medicare and Medicaid programs to offer all residents influenza and pneumococcal vaccines and to document the results. According to requirements, each resident is to be vaccinated unless contraindicated medically, the resident or legal representative refuses vaccination, or the vaccine

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F 334	Continued From page 18 is not available because of storage. This information is to be reported as part of the CMS Minimum Data Set, which tracks nursing home health parameters. Information obtained from <<http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm>>	F 334		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility failed to serve food at a palatable temperature per resident preference on one of four facility units, the first floor unit. The items served on the lunch test tray were not at a palatably hot temperature on 4/12/16. The findings include: A group interview was conducted on 4/12/16 at 10:30 a.m. During the course of the interview, residents identified food temperatures as a concern. A test tray observation was conducted during the lunchtime meal on 4/12/16. The holding temperatures (taken at 11:45 a.m.) of the food on	F 364	It is the practice of this facility to serve food at a palatable temperature. I. No individual resident was identified. II. Residents residing in the facility have the potential to be affected by this deficient practice. III. Food service staff was educated on serving food in a timely manner and at a palatable temperature. Education to staff providing meal delivery on the nursing units was provided to enforce the need for prompt delivery of trays. IV. The Food Service Director (FSD) will monitor meal delivery and food temperatures at the point of delivery to ensure food is served at a	

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F 364	Continued From page 19 the steam table were as follows (all degrees Fahrenheit): baked chicken - 186; rice - 187; baked fish - 180; pureed bread - 180; pureed chicken - 151; pureed vegetables - 170; chopped meat - 171; fortified potatoes - 190. The test tray was requested and plated at 1:42 p.m., and the cart arrived on the first floor unit at 1:45 p.m. After all other trays on the cart were distributed at 2:10 p.m., OSM (other staff member) #1, the cook/supervisor, tested the temperatures on the test tray in the presence of two surveyors. The temperatures were as follows (all degrees Fahrenheit): baked chicken - 126; rice - 113; baked fish - 124; pureed bread - 107; pureed chicken - 108; pureed vegetables - 110; chopped meat - 120; fortified potatoes - 110. OSM #1 and the two surveyors tasted these items. OSM #1 was asked to describe the temperatures of the food. He stated: "It's not a hot meal. It's sort of warm. But we can't control that." The two surveyors agreed that the food was not hot, and not at a palatable temperature for a hot meal. On 4/12/16 at 3:10 p.m., OSM #2, the food services director, was interviewed regarding these concerns regarding food temperatures. She stated: "It never takes that long to get the food out on the carts. I honestly don't know what happened." She stated that it usually only takes between 45 minutes to an hour to get all the food on the last trays and served to the residents. She stated: "I'm sure there were problems with it being hot enough. It took too long." On 4/12 16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate	F 364	palatable temperature. This audit will be performed on one meal per day for two weeks, three meals per week for two weeks and then randomly for the following two weeks to ensure substantial compliance. The Administrator will review the audits and report findings to the Quality Assurance Committee. The Committee will determine the need for adjustments to this plan if required. V. 5/28/16	

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F 364	Continued From page 20 consultant, were notified of these concerns. A review of the facility policy entitled "Food Temperature Maintenance During Holding" revealed, in part, the following: "Foods are held at temperatures to promote palatability and maintain quality of meals, prevent bacterial growth and retain nutritive value." A review of the facility policy entitled "Food Temperatures at Point of Service" revealed, in part, the following: "Doors to delivery carts are kept closed as much as possible. Trays are served promptly after arriving in patient areas. Meal rounds and other patient interviews are used to check satisfaction with food temperatures." No further information was provided prior to exit.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to prepare and store food in a	F 371	It is the practice of this facility to prepare and store food in a sanitary manner. I. The ovens were cleaned on 4/12/16. The food found in the freezer, open to air was discarded. II. Residents residing in the facility have the potential to be affected by this deficient practice. Kitchen equipment was inspected and appropriate action taken to ensure cleanliness	

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sanitary manner.

Two ovens contained baked on debris, and the handles of both ovens were greasy.

Three containers of food were open to air in the walk-in freezer.

The findings include:

Observation of the kitchen was conducted on 4/11/16 at 6:10 p.m. OSM (other staff member) #1, the cook/supervisor, accompanied the surveyor on this observation.

The two facility ovens both were observed to contain black and brown debris baked on the glass windows. The interior surfaces of the oven contained scattered black debris. The handles of both ovens were greasy and grimy.

OSM #1 was asked to describe the ovens. He stated: "Yes, they could both be cleaned." When asked how often the ovens are cleaned, he stated: "I know we do a deep cleaning like once a month. I really couldn't tell you when these were cleaned last. The person who would know that information is not here right now."

The walk-in freezer contained one box of pre-cooked omelets. The omelets were in a plastic bag, and the bag was open to air. The freezer also contained a plastic bag of Polish sausages and a bag of biscuits. Both of these bags were open to air. The biscuits had frozen ice crystals on them.

OSM #1 was asked about the frozen food open to air. He stated: "Those bags should be closed.

of the equipment. The freezer/refrigerator was inspected to ensure all items were sealed and marked appropriately.

III. Food Service staff was educated on the proper storage of food items. Food Service staff was educated on the expectations related to the cleaning schedule which includes cleaning of the oven.

IV. The Food Service Director or her designee will conduct daily sanitation rounds to ensure the cleaning schedule is being followed, the cleanliness of the equipment and the safe storage of food items. These rounds will be documented on the audit tool. This inspection will occur daily to ensure substantial compliance. The compliance will be

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They should not be open to air."

On 4/12/16 at 3:10 p.m., OSM #2, the food services director, was interviewed regarding these concerns. She stated: "The ovens get deep cleaned at least once a month. They should be wiped down after each use, and cleaned daily." When asked if she saw the ovens when she arrived at the facility that morning, and she stated: "Yes. I agree. It was pretty dirty. I had been fussing at them about it." She stated that the items in the freezer should have been closed, and that the open bags were thrown away. She stated: "You have to trash it because you just don't know."

On 4/12 16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate consultant, were notified of these concerns.

A review of the facility policy entitled "Cleaning Procedure - Ovens" revealed, in part, the following: Remove shelves and take to ware washing area...Prepare a solution according to manufacturer's guidelines of grease cutter and water in a spray bottle...Spray entire surface of the oven. Allow to soak for 15 minutes...Using a brush or scrub pad, scrub all surfaces to loosen the burned on soil...Rinse with clean cloth and wipe dry with clean cloth."

A review of the facility policy entitled "Storage of Food" revealed, in part, the following: "Seal and label open frozen foods. Frozen foods maintained in a frozen state are biologically safe indefinitely but may deteriorate in quality over time."

reported to the Quality Assurance Committee. The Committee will determine the need for adjustments to this plan if required.

V. 5/28/16

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F 371	Continued From page 23 No further information was provided prior to exit.	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. 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 physician reviewed the total plan of care at each visit for one of 25 residents in the survey sample, Resident #5. Resident #5's physician failed to review all orders on the physician's order summaries prior to signing them. The findings include: Resident #5 was admitted to the facility on 8/5/08 and readmitted to the facility on 5/7/13, 5/18/15 and 1/8/16. Resident #5's diagnoses included but were not limited to: *diabetes, heart failure and **hyperlipidemia. Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/6/16, coded the resident's cognition as being severely	F 386	It is the practice of this facility to ensure the physician reviews the total plan of care at each visit for each resident. I. The physician reviewed the plan of care for resident #5 on 4/16/16. A physician order for LFT, HHGA1C, FLP, CDC and BMP every six months was established. The facility's Medical Director reviewed the plan of care for resident #5 on 4/29/16. II. Residents under the care of ASM#4 have the potential to be affected by this deficient practice. An audit of the current plan of care for residents being treated by ASM#4 was conducted to ensure the plan of care was reviewed and orders were in place as directed. III. ASM#4 was educated on the requirement of reviewing	

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impaired.

Resident #5's readmission physician's order summary dated 5/18/15 was signed by the physician on 5/19/15. A July 2015 physician's order summary was signed by the physician on 7/13/15. Physician's order summaries for August 2015, September 2015 and October 2015 were signed by the physician on 12/2/15. A physician's order summary for November 2015 was signed by the physician on 3/15/16.

Resident #5's readmission physician's orders dated 5/18/15 (signed by the physician on 5/19/15) documented an order for weekly lab tests but failed to document an order for an LFT (Liver function tests) ***, HGA1C (Hemoglobin A1c)****, FLP (Fasting lipid panel)****, CBC (complete blood count) ^* and BMP (Basic metabolic panel) ^** every six months in May and November; however, a physician's order summary signed by the physician on 7/13/15 documented an order dated 8/1/14 for "LFT, HGA1C, FLP, CBC, AND BMP Q (every) 6 MONTHS STARTING FROM 5/9/13. (MAY/NOV [November])..." The physician's order summary signed by the physician on 7/13/15 was the most recently signed summary prior to November 2015.

On 4/13/16 at 9:15 a.m., an interview was conducted with RN (registered nurse) #2 and ASM (administrative staff member) #2 (the director of nursing), regarding a concern that Resident #5's laboratory (lab) tests were not obtained per physician's orders. Per the physician's order summary signed by the

the resident's total plan of care. Physicians treating patients at this facility were educated on the requirement of reviewing the resident's total plan of care.

IV. The Medical Records staff will monitor this review each month and report findings to the Administrator. The facility will follow the established procedure to ensure the physician remains in compliance with the requirement. The Administrator will report findings to the Quality Assurance Committee. The Committee will determine the need for adjustments to this plan if required.

V. 5/28/16

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physician on 7/13/15, lab tests were ordered every six months and were due November 2015. The lab tests were not obtained. ASM #2 stated Resident #5 went to the hospital on 5/11/15 and was readmitted on 5/18/15. ASM #2 stated Resident #5 was readmitted to the facility on 5/18/15 with new orders and the orders for labs every six months (due in November) should have dropped off of the physician's order summaries (printed after the May readmission). ASM #2 was made aware Resident #5's physician signed an order summary on 7/13/15 that documented an order for the labs every six months in May and November. ASM #2 was asked if the physician reviews the physician order summaries when he signs them. ASM #2 stated this surveyor should speak to the physician.

On 4/13/16 at 10:02 a.m., a telephone interview was conducted with ASM #4 (Resident #5's physician). ASM #4 was made aware of the above findings. ASM #4 stated he normally orders routine labs every six months to monitor residents' medications. ASM #4 stated he was ultimately responsible to make sure labs were done and the labs should have been done if there was an order for them. ASM #4 stated he doesn't necessarily review each page of each resident's physician's order summaries and he just assumes they are copies. At this time, for clarification purposes, this surveyor asked ASM #4, "You don't read each page of the POSs (physician's order summaries) that you sign?" ASM #4 explained he had multiple residents at multiple facilities and stated, "You would spend all day reading those things." ASM #4 stated he signs everything. ASM #4 stated staff puts a piece of paper in front of him and he signs it.

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On 4/13/15 at 11:05 a.m., ASM #1 and ASM #2 were made aware of the above information.

The facility document titled, "Medical Provider Responsibilities and Guidelines" documented in part, "6. The attending physician or designated medical provider should maintain progress notes and make appropriate revisions to the patient's total program of care. The progress notes and revisions to the program of care should be legible and should cover relevant information about significant ongoing, active or potential problems including at a minimum prognosis and changes in rehabilitation and other appropriate goals. The physician should review and approve each program of care..."

*"Diabetes is a disease in which your blood glucose, or blood sugar levels are too high." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=diabetes
**Hyperlipidemia is high levels of cholesterol in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cholesterol.html

***"Liver function tests are common tests that are used to see how well the liver is working." This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/003436.htm
***"A1C is a blood test for type 2 diabetes and prediabetes. It measures your average blood glucose, or blood sugar level over the past 3

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F 386	Continued From page 27 months." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=hemoglobin+a1c *****"The lipid profile is used as part of a cardiac risk assessment to help determine an individual's risk of heart disease and to help make decisions about what treatment may be best if there is borderline or high risk." This information was obtained from the website: https://labtestsonline.org/understanding/analytes/lipid/tab/test ^*The CBC measures different components in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/003642.htm ^**The BMP measures different chemicals in the blood. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=bmp	F 386		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident 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 days thereafter. 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	F 387	It is the practice of this facility to ensure timely physician visit for each resident. I. The physician visited resident #5 on 4/7/16. The next visit is due 5/7/16. II. Residents residing in the facility have the potential to be affected by this deficient practice. An audit of	

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by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure timely physician visits for one of 25 residents in the survey sample, Resident #5.

The physician did not examine Resident #5 from 9/11/15 until 12/2/15 (a period of 82 days) and from 12/10/15 until 3/15/16 (a period of 96 days).

The findings include:

Resident #5 was admitted to the facility on 8/5/08 and readmitted to the facility on 5/7/13, 5/18/15 and 1/8/16. Resident #5's diagnoses included but were not limited to: *diabetes, heart failure and **hyperlipidemia.

Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/6/16, coded the resident's cognition as being severely impaired. Review of Resident #5's payer setup information revealed the resident's payer source from 9/11/15 through 3/15/16 was Medicaid.

Review of Resident #5's clinical record revealed the physician did not examine Resident #5 from 9/11/15 until 12/2/15 (a period of 82 days) and from 12/10/15 until 3/15/16 (a period of 96 days).

On 4/12/16 at 5:55 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

On 4/13/16 at 7:45 a.m., an interview was conducted with OSM (other staff member) #5 (the

physician visits was conducted and any physician's visits found to be delinquent was acted on appropriately.

III. Physicians treating patient in the facility were educated on the frequency requirement of physician visits on 4/29/16. Medical Records staff was educated on reporting delinquent physician visits to the Administrator.

IV. The Medical Records staff will conduct monthly audits to ensure timely physician visits for our residents. Audit finding will be presented to the Administrator for further follow up if needed. The Administrator will report findings to the Quality Assurance Committee. The Committee will determine the need for adjustments

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person responsible for tracking physicians' visits). OSM #5 stated she tracks physicians' visits with a log. OSM #5 stated if a physician visit is overdue, she (OSM #5) sends certified paperwork to the physician to make them aware. OSM #5 stated she also notifies the medical director, explains the doctor hasn't complied and explains what is needed. OSM #5 stated sometimes the medical director replies and sometimes he does not. OSM #5 stated sometimes the physician visits are late and sometimes the physicians don't comply. OSM #5 was asked how often residents are supposed to be seen by the physician. OSM #5 stated the physicians are supposed to see residents within 30 days of admission, every 30 days for 90 days, then at least once every 60 days.

On 4/13/16 at 8:30 a.m., OSM #5 provided a copy of a certified mail receipt and a copy of a letter addressed to Resident #5's physician that documented, "DATE: 11-13-2015; Dear (name of physician), In reviewing our clinical records, it was noted that the following patient for whom you are the attending physician is overdue for a physician visit. One of the requirements for our certification under Medicare and Medicaid, is that each patient is visited by their physician according to time frames outlined in the regulation. At each of these visits you are responsible for reviewing and signing all orders and other incomplete documentation and for writing a progress note regarding the condition of the patient..." Resident #5's name was documented on the letter. OSM #5 stated she sent the letter to Resident #5's physician in November 2015 and the physician didn't respond. At this time, OSM #5 was asked to provide any further information regarding Resident #5's physician's visits between 12/10/15

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F 387	Continued From page 30 and 3/15/16. OSM #5 stated she would look. On 4/13/16 at 9:12 a.m., ASM #1 and ASM #2 were made aware of the above information. On 4/13/16 at 11:05 a.m., ASM #1 stated OSM #5 did not have any further information. The facility document titled, "Monitoring Physician Visits and Documentation" documented in part, "It is important that the following guidelines are monitored to ensure physician visits are timely and documented in the electronic health record: -patients are seen by a physician within 30 days of admission, every 30 days for the first 90 days after admission and at least once every 60 days thereafter or per state regulations. -A physician visit is considered timely if it occurs within 10 days of the date the visit was required or as otherwise stipulated by state regulations..." *"Diabetes is a disease in which your blood glucose, or blood sugar levels are too high." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=diabetes **Hyperlipidemia is high levels of cholesterol in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cholesterol.html	F 387		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502	It is the practice of this facility to obtain physician ordered laboratory tests. I. Resident #5 had laboratory tests (LFT, HGA1C, FLP, CBC	

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to obtain physician ordered laboratory tests for one of 25 residents in the survey sample, Resident #5.

The facility staff failed to obtain laboratory tests (including a *LFT [liver function tests], **HGA1C [hemoglobin A1C], ***FLP [fasting lipid panel], ****CBC [complete blood count], and *****BMP [basic metabolic panel]) every six months per physician's orders.

The findings include:

Resident #5 was admitted to the facility on 8/5/08 and readmitted to the facility on 5/7/13, 5/18/15 and 1/8/16. Resident #5's diagnoses included but were not limited to: ******diabetes, heart failure and *******hyperlipidemia.

Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/6/16, coded the resident's cognition as being severely impaired.

Resident #5's readmission physician's orders dated 5/18/15 (signed by the physician on 5/19/15) documented an order for weekly lab tests but failed to document an order for an LFT, HGA1C, FLP, CBC and BMP every six months in May and November; however, a physician's order summary signed by the physician on 7/13/15 documented an order dated 8/1/14 for "LFT, HGA1C, FLP, CBC, AND BMP Q (every) 6

and BMP) performed on 4/13/16. The results were received and the physician was notified.

II. Residents being readmitted to the facility with recurring lab orders have the potential to be affected by this deficient practice. An audit of resident readmitted during the past 90 days was audited to ensure recurring lab orders were renewed at the time of readmission. Any discrepancies found were corrected and the physician was notified.

III. Education was provided to licensed nursing staff related to the process to ensure prior recurring orders are carried over on the physician orders at the time of a readmission to the facility.

IV. The Director of Nursing or her

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F 502	Continued From page 32 MONTHS STARTING FROM 5/9/13. (MAY/NOV [November])..." The physician's order summary signed by the physician on 7/13/15 was the most recently signed summary prior to November 2015. Further review of Resident #5's clinical record failed to reveal results of the above ordered laboratory (lab) tests for November 2015. The clinical record only contained lab tests obtained in May 2015 and April 2016. Resident #5's November 2015 eTAR (electronic treatment administration record) documented the physician's order for the above lab tests but failed to document the lab tests were obtained. Resident #5's comprehensive care plan initiated on 5/8/13 documented, "Focus: Cardiac disease related to Hypertension (high blood pressure), hyperlipidemia, obesity, cad (coronary artery disease). Interventions: Obtain Lab results as ordered and notify physician of results...Focus: Endocrine System related to Diabetes. Interventions: Obtain Lab results as ordered and notify physician of results..." Physician's progress notes dated 5/22/15, 5/27/15, 6/3/15, 6/12/15, 6/23/15, 7/13/15, 8/11/15, 9/11/15, 12/2/15, 12/10/15, 3/15/16, 3/24/16 and 4/7/16 documented, "Labs: LFT, HbA1C, FLP, CBC, BMP q (every) 6 mos (months)..." On 4/12/16 at 5:26 p.m., an interview was conducted with RN (registered nurse) #2 and ASM (administrative staff member) #2 (the director of nursing). RN #2 and ASM #2 were asked to provide evidence to show Resident #5's	F 502	designee will monitor the physician orders for readmitting residents to ensure recurring orders are continued as directed by the physician. The DON will document her findings on the Admission tool and present the tool to Quality Assurance Committee. The Committee will determine the need for adjustments to this plan if required. V. 5/28/16	

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lab tests were obtained every six months per physician's orders. ASM #2 stated there were no further lab test results for Resident #5. ASM #2 stated Resident #5's lab tests had been put on hold during different hospitalizations. ASM #2 showed this surveyor Resident #5's hospitalization dates. RN #2 stated Resident #5's physician assistant had ordered the lab tests in 2013 and the physician's order summaries should have been updated to remove the order for a LFT, HbA1C, FLP, CBC and BMP in May and November. RN #2 and ASM #2 were made aware Resident #5's physician signed an order summary on 7/13/15 that documented an order for a LFT, HGA1C, FLP, CBC and BMP every six months in May and November and was asked to provide the labs or any further information.

On 4/12/16 at 5:55 p.m., ASM #1 (the administrator) and ASM #2 were asked to provide evidence that Resident #5's labs were obtained every six months per physician's orders.

On 4/13/16 at 9:15 a.m., an interview was conducted with RN #2 and ASM #2 regarding the facility process to ensure lab tests are obtained per physician's orders. ASM #2 stated staff puts the orders in the eMAR (electronic medication administration record), documents the orders on the 24 hour report and enters the orders into a computer system that communicates with the lab. ASM #2 stated a technician from the lab comes to the facility seven days a week to obtain lab tests. ASM #2 stated Resident #5 went to the hospital on 5/11/15 and was readmitted on 5/18/15. ASM #2 stated Resident #5 was readmitted to the facility on 5/18/15 with new orders and the order for a LFT, HGA1C, FLP, CBC and BMP every six months in May and

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November should have dropped off of the physician's order summaries. ASM #2 was made aware Resident #5's physician signed an order summary on 7/13/15 that documented an order for an LFT, HGA1C, FLP, CBC and BMP every six months in May and November. ASM #2 was asked if the physician reviews the physician's order summaries when he signs them. ASM #2 stated this surveyor should speak to the physician.

On 4/13/16 at 10:02 a.m., a telephone interview was conducted with ASM #4 (Resident #5's physician). ASM #4 was made aware of the above findings. ASM #4 stated he normally orders routine labs every six months to monitor residents' medications. ASM #4 stated someone would have had to put the 8/1/14 order for a LFT, HGA1C, FLP, CBC, AND BMP every six months back into the computer system because the order couldn't have just appeared (on the physician's order summary). ASM #4 stated he was ultimately responsible to make sure labs were done and the labs should have been done if there was an order for them.

On 4/13/15 at 11:05 a.m., ASM #1 and ASM #2 were made aware of the above information.

The facility document titled, "Laboratory Tracking Guidelines" documented in part, "Lab tests and, or services are provided: in accordance, with a signed contract for services that specifies what services are provided by the center staff and what services are provided by the laboratory staff; and within what timeframe those services are provided including the draw completion and reporting of STAT, routine, critical or panic value lab results; the provision of requisitions and, or

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lab draw supplies when specifically ordered by the attending physician or physician extender..."

*"Liver function tests are common tests that are used to see how well the liver is working." This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/003436.htm

**"A1C is a blood test for type 2 diabetes and prediabetes. It measures your average blood glucose, or blood sugar level over the past 3 months." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=hemoglobin+a1c

***"The lipid profile is used as part of a cardiac risk assessment to help determine an individual's risk of heart disease and to help make decisions about what treatment may be best if there is borderline or high risk." This information was obtained from the website: https://labtestsonline.org/understanding/analytes/lipid/tab/test

****The CBC measures different components in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/003642.htm

*****The BMP measures different chemicals in the blood. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=bmp

******"Diabetes is a disease in which your blood glucose, or blood sugar levels are too high." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-

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MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 502	Continued From page 36 meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=diabetes *******Hyperlipidemia is high levels of cholesterol in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cholesterol.html	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 25 residents in the survey sample, Resident #10. The facility staff failed to document Resident #10's refusal to have physician ordered laboratory tests drawn. The findings include:	F 514	It is the practice of this facility to maintain a complete and accurate clinical record. I. The plan of care for resident #10 was updated to include refusal of treatment, specifically the refusal of laboratory tests. II. Residents exhibiting the behavior of refusing laboratory tests have the potential to be affected by this deficient practice. An IDT review was conducted to determine which, if any other resident exhibit behaviors of refusing laboratory test. The plan of care for identified residents was completed. III. Education was provided to	

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Resident #10 was admitted to the facility on 4/11/14 and readmitted to the facility on 11/11/14. Resident #10's diagnoses included but were not limited to: *bipolar disorder and **anemia.

Resident #10's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 2/24/16, coded the resident as being cognitively intact. Section E documented Resident #10 had not rejected care during the look back period.

Review of Resident #10's clinical record revealed a physician's order summary signed by the physician on 2/11/16 that documented an order dated 11/20/14 for a ***CBC (complete blood count) and ****BMP (basic metabolic panel) every six months. Further review of Resident #10's clinical record revealed a CBC and BMP were obtained on 5/21/15, 2/1/16 and 2/4/16. Resident #10's eTARs (electronic treatment administration record) documented the physician's order for a CBC and BMP every six months but failed to document the labs were obtained during the months of June 2015 through January 2016.

On 4/12/16 at 5:26 p.m., RN (registered nurse) #2 and ASM (administrative staff member) #2 (the director of nursing) were asked to provide evidence that a CBC and BMP were obtained from Resident #10 every six months.

On 4/12/16 at 5:55 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above findings.

On 4/13/16 at 9:15 a.m., an interview was conducted with RN #2 and ASM #2. ASM #2

licensed nurses related to the appropriate documentation and notification required when a resident refuses care/treatment and how to communicate any refusal to the IDT for further follow-up via the 24-hour report form.

IV. The IDT will review the 24-hour report for in the daily clinical review meeting to determine if a resident is refusing care/treatment and that the proper documentation is in the clinical record. A plan of care to address refusal of care/treatment will be developed as appropriate. The IDT's review will be document on the audit tool. The audit tool will be presented to the Quality Assurance Committee for review. The Committee will determine the need for adjustments to this plan if

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stated Resident #10's CBC and BMP were obtained in May 2015 and due again in November or December but the resident refused to have the labs obtained. ASM #2 stated during November and December 2015, Resident #10 refused care and refused to eat so the resident was seen by a psychiatrist who ordered antidepressant medication and a urinalysis. ASM #2 stated Resident #10 was eventually sent to the hospital for an evaluation due to her refusal of care and food. ASM #2 was asked to provide documentation that Resident #10 refused lab tests. ASM #2 stated she could not show any specific documentation that the resident refused lab tests but she could provide the resident's care plan and this surveyor could talk to nursing staff.

Resident #10's nurses' progress notes for October 2015 through December 2015 documented the resident refused meals and refused to be weighed; however, the nurses' progress notes failed to document Resident #10's refusal of lab tests.

Resident #10's comprehensive care plan created on 4/14/14 documented, "Focus: Non-compliant with treatment/care (refuses to get out of bed, refuses to go for appointment, refuses shower, refuses to eat)/ refuses to eat and take medication..." The care plan failed to specifically document the resident's refusal of lab tests.

On 4/13/16 at 10:50 a.m., a telephone interview was conducted with RN #8. RN #8 stated she had worked with Resident #10 for two years. RN #8 stated approximately three months ago, Resident #10 refused to eat, refused to take medication and refused lab tests. RN #8 stated the resident was sent to the hospital two times

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regarding this matter. RN #8 stated when the resident refused lab tests, she (RN #8) explained the importance of the lab tests to the resident, notified the physician and notified Resident #10's daughter. RN #8 stated she documented this information in the progress notes. RN #8 was made aware this information was not observed in the progress notes. RN #8 stated the documentation was in the progress notes in the computer and she was pretty sure she documented this information in November 2015.

On 4/13/16 at 11:05 a.m., ASM #1 and ASM #2 were made aware of the above information. ASM #2 was asked to review Resident #10's progress notes for documentation of the resident's refusal of lab tests. On 4/13/16 at 11:33 a.m., ASM #2 confirmed she didn't see documentation of Resident #10's refusal of lab tests.

Resident #10 declined to be interviewed during the survey.

The facility document titled, "Section 1: Documentation" documented in part, "Clinical records are maintained on each patient that are complete, readily accessible and systematically organized. A complete clinical record reports the actual experience of the individual and contains sufficient information to validate patient status and outcomes of care provided..."

*"Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/bipolardisor

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F 514	Continued From page 40 der.html ***"If you have anemia, your blood does not carry enough oxygen to the rest of your body." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=anemia ***A CBC measures different components of the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/003642.htm ****A BMP measures different chemicals in the blood. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=bmp	F 514		