STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 02/04/2016

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

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 2/2/16 through 2/4/16. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 155 certified bed facility was 135 at the time of the survey. The survey sample consisted of three current Resident reviews (Residents # 5 through # 7) and four closed record reviews (Residents #1 through # 4).	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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157	F157 It is the practice of this facility to notify the physician, per the physician orders of elevated blood sugars. I. The physician for resident #5 was notified regarding the blood sugar reading of 401 on 2/18/16. The physician will be notified of any other blood sugar reading outside of the parameters for resident #5. II. Residents having physician orders to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tamara D. Webster — TITLE: Administrator — (X6) DATE: 3-4-16

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 157	Continued From page 1 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to notify the physician, per the physician order of an elevated blood sugar for one of seven residents in the survey sample, Resident #5. The physician order was to notify the physician if Resident #5's blood sugar went over 400. It went over 400 and the physician was not notified. Blood glucose values for adults is 60-100 mg/dl (1) The findings include: Resident #5 was admitted to the facility on 10/14/12 with a recent readmission on 12/30/15 with diagnoses that included but were not limited to: congestive heart failure, gastroesophageal reflux disease, glaucoma, anemia, high blood pressure, peripheral vascular disease, and diabetes. The most recent MDS (minimum data set)	F 157	be notified when blood sugar readings are outside of ordered parameters have the potential to be affected. An audit of residents on insulin was performed. Identified residents were reviewed to ensure appropriate parameters were in place. III. Nursing staff was educated on following physician orders and notifying the physician when the order indicates. An audit of residents on insulin was performed. Identified residents were reviewed to ensure appropriate parameters were in place. IV. Residents on insulin will be audited to ensure the physician is notified when a blood sugar reading is outside of the parameters as indicated on the physician order. This audit will occur 5 times a week for 2 weeks, 2 times a week for the following 2 weeks and then once per week for the following 4 weeks. Results of the audit will be reviewed	

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F 157	Continued From page 2 assessment, a Medicare 14 day assessment, with an assessment reference date of 1/11/16, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or two people for all of his activities of daily living. In Section N - Medications, the resident was coded as having received insulin injections fur the past seven days of the look back period. The physician order dated, 12/31/15, documented in part: "Sliding scale insulin with Novolog Solution 100 units/ML (units per milliliter) ...if BS (blood sugar) 401 + (plus) = (equals) give 10 units; If BS > (greater than) 400, give insulin and call doctor, subcutaneously before meals and at bedtime for dm (diabetes mellitus)." The Medication Administration Record (MAR) for January 2016 documented in part: "Sliding scale insulin with Novolog solution 100 units/ML (units per milliliter) ...if BS (blood sugar) 401 + = give 10 units; If BS > (greater than) 400, give insulin and call doctor, subcutaneously before meals and at bedtime for dm (diabetes mellitus)." On 1/19/16, the 11:00 a.m. blood sugar was documented as 401. Ten units of insulin was documented as administered. Review of the Progress Notes, dated 1/19/16, did not reveal any documentation the physician was notified of Resident #5's 401 mg/dl (milligram/deciliter) blood sugar reading as ordered. The comprehensive care plan, dated, 6/10/13 with a revision on 12/27/15, documented, "Focus:	F 157	by the Administrator and submitted to the QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits and or action plans V. 3/4/16	

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F 157	Continued From page 3 Endocrine System related to; Insulin Dependent Diabetes." The "Interventions" documented, "Administer medications per physician orders. Report symptoms of hyperglycemia: excessive thirst/urination, hunger, weakness, N/V (nausea/vomiting) acetone breath." An interview was conducted with LPN (licensed practical nurse) #3 on 2/3/16 at 4:06 p.m. regarding sliding scale insulin orders with documented parameters to call the physician if the blood sugar is over 400. When asked what the nurse would do if the blood sugar was 401, LPN #3 stated, "I'd call the doctor and let him know." When asked where the call to the physician was documented, LPN #3 stated, "In the progress notes." An interview was conducted with RN (registered nurse) #6 on 2/3/16 at 4:15 p.m., regarding sliding scale insulin orders with documented parameters to call the physician if the blood sugar is over 400. When asked what the nurse would do if the blood sugar was 401, RN #6 stated, "I have to call the doctor and follow what orders he may give me." When asked where the call to the physician is documented, RN #6 stated, "I have to write a note in the progress notes." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 2/3/16 at 4:28 p.m. When asked if the physician wrote an order to be notified if the resident's blood sugar is less than 70 or over 400, what is expected of the nurse if the blood sugar is 401, ASM #2 stated, "They should have called the doctor." The facility policy, "Glucose Blood Monitoring	F 157		

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F 157	Continued From page 4 (Finger Stick Blood Sugar)" documented, "Suggested Documentation: Unusual observations and/or complaints and subsequent interventions including communications with physician." In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. ASM #1, (administrator), ASM #2, (director of nursing) and ASM #3, (the quality assurance coordinator), were made aware of the above concern on 2/3/16 at 4:30 p.m. No further information was provided prior to exit. (1) Nurse's Manual of Laboratory and Diagnostic Tests; Bonita Cavanaugh Fourth Edition page 107.	F 157		
F 204 SS=D	COMPLAINT DEFICIENCY 483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is	F 204	F204 It is the practice of this facility to provide sufficient preparation to ensure a safe discharge. I. Resident #3 was discharged from the facility on 8/22/15.	

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F 204	Continued From page 5 the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to provide sufficient preparation to ensure a safe discharge for one of seven residents in the survey sample, Resident #3. The facility staff failed to assess the resident's need for a mechanical lift prior to discharge. Also, the facility staff knew Resident #3 did not quality for needed medical equipment such as a wheelchair and a bedside commode prior to discharge. The findings include: Resident #3 was admitted to the facility on 9/24/14 with diagnoses that included but were not limited to: *multiple sclerosis (a nervous system disease that affects your brain and spinal cord), edema (swelling), urinary tract infection and high blood pressure. Resident #3's most recent MDS (minimum data set) (prior to discharge), a quarterly assessment with an ARD (assessment reference date) of 7/4/15, coded the resident as being cognitively intact. Section G coded Resident #3 as requiring extensive assistance of	F 204	II. Residents discharging from the facility who require medical equipment have the potential to be affected. III. Education was provided to staff in the social services department relating to preparation for safe discharge. Residents discharging from the facility will be reviewed by the IDT to ensure sufficient preparation related to medical equipment is provided to ensure a safe discharge. This review will be documented in the clinical record as a progress note. The Administrator will audit discharge progress notes to ensure compliance. This audit will occur 2 times a week for two weeks then once weekly for 4 weeks. IV. Results of the audits will be reviewed by the Administrator and submitted to the QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits and or action plans	

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F 204	Continued From page 6 one staff with bed mobility, locomotion, eating and personal hygiene. Section G coded the resident as requiring extensive assistance of two or more staff with transfers, toilet use and being totally dependent of one staff with bathing. G0600 documented Resident #3 normally used a wheelchair. Resident #3 was discharged from the facility on 8/22/15. A physical therapy discharge summary dated 5/13/15 documented, "Interventions Provided: Pt (Patient) is evaluated s/p (status post) referral from the nursing. PT intervention focused on increasing pts independence with bed mobility and transfers with thera acts, thera exercise and neuro (neurological) re-education. Pt has made slow progress with therapy. Pt is min to mod A (minimum to moderate assist) with sit to stand in the bar and min A to mod A with squat pivot transfer. However, pt progress is not functional enough for safe transfers. Pts performance varies depending on the muscle fatigue 2/2 (sic) (secondary to) to progressing MS (multiple sclerosis). Pt is currently discharging from therapy 2/2 to pt has reached maximum functional potential..." A social services note dated 8/19/15 documented, "SW (Social Worker) received a voicemail from the resident stating her housing did not work. She stated her house renovations will not be complete until October 1st and that she will not be discharging from the facility until then. She did ask for a copy of her payment to the facility. SW did provide the invoice to her. SW notified the Administrator about the resident's statement of not leaving the facility until October 1st. SW did receive voicemail from the resident's landlord	F 204	V. 3/4/16	

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F 204	Continued From page 7 stating the house will not be accessibly (sic) until October 1st. SW approached the resident to discuss other housing options with her. One of them was to have resident stay at an extended stay hotel for the next few weeks. SW stated that resident will receive home health therapy at the hotel. Resident did seem to be open to the hotel option. SW did pull up hotel rates in the local area. Later in the afternoon, the resident notified the SW and the Administrator that she did locate a house. This house is handicapped accessible and in a basement level home. She has a hospital bed in the bedroom from the previous owner. SW confirmed with the resident her DME (durable medical equipment) she will be receiving. The following pieces will be ordered: 3 in 1 commode, reacher, transfer board, wheelchair, and a shower bench. SW put the order in with (name of medical equipment company). Per the resident's request, SW called (name of home health agency) for custodial care and skilled services. SW faxed the request of home PT (physical therapy), OT (occupational therapy), RN (registered nurse) to the head nurse of (name of home health agency). A representative from the Money Follows the Person conducted an assessment with the resident. This program can possibly provide financial assistance to the home renovations. SW notified the resident that on the day of discharge of 8/22/15, medical transport will be coming to pick her up around 12:30 p.m. SW will continue to follow up as needed and assist with the discharge planning." A social services note dated 8/20/15 documented, "SW received a message from (name of company to provide durable medical equipment) via fax that her wheelchair and bedside commode	F 204		

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will not be delivered. In 2009, the resident ordered the equipment and will not qualified (sic) until 2016 to get new equipment. SW notified the resident about the update on equipment. SW provided her a copy of the documents that showed her past order in 2009. Resident stated she will find a way to locate her equipment at her home. SW also provided her a resource to assist her with moving her belongings from the facility to her home. SW made transportation arrangements with (name of transportation company) for the day of discharge. SW will continue to follow up as needed."

Resident #3's comprehensive care plan initiated on 2/15/15 and revised/cancelled on 4/2/15 documented, "Patient does not show potential for discharge to the community due to physical care needs...Interventions: Reassess care needs and potential for discharge as needed. Support patient, family and/or representative as needed..."

On 2/3/16 at 10:32 a.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated she wasn't sure but she thought Resident #3 used a standing lift.

On 2/3/16 at 10:50 a.m., an interview was conducted with OSM (other staff member) #9, the occupational therapist who worked with Resident #3 in May 2015. OSM #9 stated in May 2015, the resident required maximum assistance of one staff with transfers, using the stand and pivot method. OSM #9 stated the resident did not want to use a sliding board. OSM #9 stated she saw Resident #3 a lot after May and the resident "rolled herself to activities" and maintained her level of function from May.

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F 204	Continued From page 9 On 2/3/16 at 1:45 p.m., an interview was conducted with OSM #4, the social worker. OSM #4 stated Resident #3 was discharged due to financial issues and wasn't paying her bill. OSM #4 stated the resident was discharged on 8/22/15 and the home health agency was scheduled to enter within 24 or at most 48 hours. OSM #4 stated Resident #3 requested a wheelchair and bed side commode. OSM #4 stated the resident received those items in 2009 and would not qualify for those items again until 2016. OSM #4 stated on the day of Resident #3's discharge, she (OSM #4) spoke to a nurse who stated the resident borrowed a wheelchair from the facility. OSM #4 stated Resident #3 only needed assistance into a wheelchair. When asked how the resident required assistance with showering, toileting and dressing, OSM #4 stated she thought Resident #3 used a Hoyer lift. When asked if the lift was ordered for the resident's discharge, OSM #4 stated she didn't remember ordering the lift. When asked if Resident #3 was assessed by the therapy department prior to her discharge, OSM #4 stated she always got the green light from the therapy department. OSM #4 further stated someone from the county assessed Resident #3. OSM #4 stated the home health agency was responsible for Resident #3's follow up care. OSM #4 stated she remembered a mechanical lift was not requested by Resident 3 or the facility staff. On 2/3/16 at 2:02 p.m., an interview was conducted with CNA #2 regarding Resident #3. CNA #2 stated Resident #3 required a lift and staff was using a stand lift to get the resident up. On 2/3/16 at 2:18 p.m., an interview was conducted with OSM (other staff member) #1, the	F 204		

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F 204	Continued From page 10 business office manager. OSM #1 stated Resident #3 was discharged because she didn't pay her bill. OSM #1 stated she should have a copy of the discharge notice on file. (Note- review of the discharge letter revealed Resident #3 was notified on 7/23/15 that she would be discharged on 8/22/15 due to failure to maintain her account and having had a balance of $6,263). On 2/3/16 at 2:25 p.m., an interview was conducted with RN (registered nurse) #3, regarding Resident #3. RN #3 stated the resident was alert and oriented times three and had problems with her legs so she transferred with a stand lift. On 2/3/16 at 2:48 p.m., an interview was conducted with CNA #3. CNA #3 stated Resident #3 was totally dependent of one staff with bed mobility and required a sit and stand lift with transfers and toileting. CNA #3 was asked if anyone talked to her regarding Resident #3's needs prior to discharge and stated no one had talked to her and she just knew the resident was leaving. On 2/3/16 at 4:40 p.m. an interview was conducted with OSM #10, the physical therapist who worked with Resident #3 in May 2015. OSM #10 stated Resident #3 required a maximum assistance of the Hoyer lift with two or three people for transfers. OSM #10 stated the resident wanted to go home alone so staff explained the process of what was required for the resident's care. OSM #10 stated she wasn't involved with Resident #3's discharge in August but she had attended previous care plan meetings. OSM #10 stated Resident #3 insisted on going home. OSM #10 stated she thought the	F 204		

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F 204	Continued From page 11 resident was discharged with a commode and wheelchair but not a lift. OSM #10 stated Resident #3 didn't want anyone with her (at home). On 2/3/16 at 4:48 p.m., another interview was conducted with OSM #4 (the social worker). OSM #4 stated she did not have a discussion with anyone regarding a mechanical lift prior to Resident #3's discharge. OSM #4 stated she talked to therapists, nurses and CNAs about Resident #3 and she thought the resident was at an independent level for operating her wheelchair. OSM #4 stated Resident #3 was not discharged with a wheelchair or bed side commode. OSM #4 stated the resident took a wheelchair from the facility but wasn't supposed to. OSM #4 stated she called a company to coordinate Resident #3's medical equipment after the resident was discharged. OSM #4 stated the therapy department didn't recommend Resident #3 to have a lift and stated she needed a sliding board and home health therapist. OSM #4 stated she remembered the resident saying she was fine with a sliding board. On 2/3/16 at 5:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated during discharge plan meetings, staff talks about what residents need. ASM #2 stated she wasn't really involved in Resident #3's discharge. On 2/3/16 at 5:30 p.m., ASM #1, the administrator and ASM #2 were made aware of the above concern. The facility document titled "Clinical Services: Discharge Planning" documented in part,	F 204		

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F 204	Continued From page 12 "Discharge planning is a collaborative effort between all departments to assist the patient in smoothly transitioning to the next desired care setting in their community or to a long term placement option. This is achieved through compliant patient centered care that focuses on the patients and their goals with every admission, care plan, therapy encounter and discharge..." No further information was presented prior to exit. * This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/multiplesclerosis.html COMPLAINT DEFICIENCY	F 204		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document, and in the course of a complaint investigation review, it was determined that the facility staff failed to provide medically related social services for one of seven residents in the survey sample, Resident #3. The facility staff failed to assess the resident's need for a mechanical lift prior to discharge. Also, the facility staff knew Resident #3 did not	F 250	F250 It is the practice of this facility to provide medically related social services. I. Resident #3 was discharged from the facility on 8/22/15. II. Residents discharging from the facility who require medical equipment have the potential to be affected. III. Education was provided to staff in the social services department relating to preparation for safe	

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F 250	Continued From page 13 quality for needed medical equipment such as a wheelchair and a bedside commode prior to discharge. The findings include: Resident #3 was admitted to the facility on 9/24/14 with diagnoses that included but were not limited to: *multiple sclerosis (a nervous system disease that affects your brain and spinal cord), edema (swelling), urinary tract infection and high blood pressure. Resident #3's most recent MDS (minimum data set) (prior to discharge), a quarterly assessment with an ARD (assessment reference date) of 7/4/15, coded the resident as being cognitively intact. Section G coded Resident #3 as requiring extensive assistance of one staff with bed mobility, locomotion, eating and personal hygiene. Section G coded the resident as requiring extensive assistance of two or more staff with transfers, toilet use and being totally dependent of one staff with bathing. G0600 documented Resident #3 normally used a wheelchair. Resident #3 was discharged from the facility on 8/22/15. A physical therapy discharge summary dated 5/13/15 documented, "Interventions Provided: Pt (Patient) is evaluated s/p (status post) referral from the nursing. PT intervention focused on increasing pts independence with bed mobility and transfers with thera acts, thera exercise and neuro re-education. Pt has made slow progress with therapy. Pt is min to mod A (minimum to moderate assist) with sit to stand in the bar and min A to mod A with squat pivot transfer. However, pt progress is not functional enough for safe transfers. Pts performance varies depending on the muscle fatigue 2/2 (sic) to	F 250	discharge. Residents discharging from the facility will be reviewed by the IDT to ensure sufficient preparation related to medical equipment is provided to ensure a safe discharge. This review will be documented in the clinical record as a progress note. The Administrator will audit discharge progress notes to ensure compliance. This audit will occur 2 times a week for two weeks then once weekly for 4 weeks. IV. Results of the audits will be reviewed by the Administrator and submitted to the QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits and or action plans V. 3/4/16	

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F 250	Continued From page 14 progressing MS (multiple sclerosis). Pt is currently discharging from therapy 2/2 to pt has reached maximum functional potential..." A social services note dated 8/19/15 documented, "SW (Social Worker) received a voicemail from the resident stating her housing did not work. She stated her house renovations will not be complete until October 1st and that she will not be discharging from the facility until then. She did ask for a copy of her payment to the facility. SW did provide the invoice to her. SW notified the Administrator about the resident's statement of not leaving the facility until October 1st. SW did receive voicemail from the resident's landlord stating the house will not be accessibly (sic) until October 1st. SW approached the resident to discuss other housing options with her. One of them was to have resident stay at an extended stay hotel for the next few weeks. SW stated that resident will receive home health therapy at the hotel. Resident did seem to be open to the hotel option. SW did pull up hotel rates in the local area. Later in the afternoon, the resident notified the SW and the Administrator that she did locate a house. This house is handicapped accessible and in a basement level home. She has a hospital bed in the bedroom from the previous owner. SW confirmed with the resident her DME (durable medical equipment) she will be receiving. The following pieces will be ordered: 3 in 1 commode, reacher, transfer board, wheelchair, and a shower bench. SW put the order in with (name of medical equipment company). Per the resident's request, SW called (name of home health agency) for custodial care and skilled services. SW faxed the request of home PT (physical therapy), OT (occupational therapy), RN (registered nurse) to the head nurse	F 250		

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F 250	Continued From page 15	F 250		

of (name of home health agency). A representative from the Money Follows the Person conducted an assessment with the resident. This program can possibly provide financial assistance to the home renovations. SW notified the resident that on the day of discharge of 8/22/15, medical transport will be coming to pick her up around 12:30 p.m. SW will continue to follow up as needed and assist with the discharge planning."

A social services note dated 8/20/15 documented, "SW received a message from (name of company to provide durable medical equipment) via fax that her wheelchair and bedside commode will not be delivered. In 2009, the resident ordered the equipment and will not qualified (sic) until 2016 to get new equipment. SW notified the resident about the update on equipment. SW provided her a copy of the documents that showed her past order in 2009. Resident stated she will find a way to locate her equipment at her home. SW also provided her a resource to assist her with moving her belongings from the facility to her home. SW made transportation arrangements with (name of transportation company) for the day of discharge. SW will continue to follow up as needed."

Resident #3's comprehensive care plan initiated on 2/15/15 and revised/cancelled on 4/2/15 documented, "Patient does not show potential for discharge to the community due to physical care needs...Interventions: Reassess care needs and potential for discharge as needed. Support patient, family and/or representative as needed..."

On 2/3/16 at 10:32 a.m., an interview was conducted with CNA (certified nursing assistant)

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F 250	Continued From page 16 #4. CNA #4 stated she wasn't sure but she thought Resident #3 used a standing lift. On 2/3/16 at 10:50 a.m., an interview was conducted with OSM (other staff member) #9, the occupational therapist who worked with Resident #3 in May 2015. OSM #9 stated in May 2015, the resident required maximum assistance of one staff with transfers, using the stand and pivot method. OSM #9 stated the resident did not want to use a sliding board. OSM #9 stated she saw Resident #3 a lot after May and the resident "rolled herself to activities" and maintained her level of function from May. On 2/3/16 at 1:45 p.m., an interview was conducted with OSM #4, the social worker. OSM #4 stated Resident #3 was discharged due to financial issues and wasn't paying her bill. OSM #4 stated the resident was discharged on 8/22/15 and the home health agency was scheduled to enter within 24 or at most 48 hours. OSM #4 stated Resident #3 requested a wheelchair and bed side commode. OSM #4 stated the resident received those items in 2009 and would not qualify for those items again until 2016. OSM #4 stated on the day of Resident #3's discharge, she (OSM #4) spoke to a nurse who stated the resident borrowed a wheelchair from the facility. OSM #4 stated Resident #3 only needed assistance into a wheelchair. When asked how the resident required assistance with showering, toileting and dressing, OSM #4 stated she thought Resident #3 used a Hoyer lift. When asked if the lift was ordered for the resident's discharge, OSM #4 stated she didn't remember ordering the lift. When asked if Resident #3 was assessed by the therapy department prior to her discharge, OSM #4 stated she always got the	F 250		

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F 250	Continued From page 17	F 250		

green light from the therapy department. OSM #4 further stated someone from the county assessed Resident #3. OSM #4 stated the home health agency was responsible for Resident #3's follow up care. OSM #4 stated she remembered a mechanical lift was not requested by Resident 3 or the facility staff.

On 2/3/16 at 2:02 p.m., an interview was conducted with CNA #2 regarding Resident #3. CNA #2 stated Resident #3 required a lift and staff was using a stand lift to get the resident up.

On 2/3/16 at 2:18 p.m., an interview was conducted with OSM (other staff member) #1, the business office manager. OSM #1 stated Resident #3 was discharged because she didn't pay her bill. OSM #1 stated she should have a copy of the discharge notice on file. (Note- review of the discharge letter revealed Resident #3 was notified on 7/23/15 that she would be discharged on 8/22/15 due to failure to maintain her account and having had a balance of $6,263).

On 2/3/16 at 2:25 p.m., an interview was conducted with RN (registered nurse) #3, regarding Resident #3. RN #3 stated the resident was alert and oriented times three and had problems with her legs so she transferred with a stand lift.

On 2/3/16 at 2:48 p.m., an interview was conducted with CNA #3. CNA #3 stated Resident #3 was totally dependent of one staff with bed mobility and required a sit and stand lift with transfers and toileting. CNA #3 was asked if anyone talked to her regarding Resident #3's needs prior to discharge and stated no one had talked to her and she just knew the resident was

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F 250	Continued From page 18 leaving. On 2/3/16 at 4:40 p.m. an interview was conducted with OSM #10, the physical therapist who worked with Resident #3 in May 2015. OSM #10 stated Resident #3 required a maximum assistance of the Hoyer lift with two or three people for transfers. OSM #10 stated the resident wanted to go home alone so staff explained the process of what was required for the resident's care. OSM #10 stated she wasn't involved with Resident #3's discharge in August but she had attended previous care plan meetings. OSM #10 stated Resident #3 insisted on going home. OSM #10 stated she thought the resident was discharged with a commode and wheelchair but not a lift. OSM #10 stated Resident #3 didn't want anyone with her (at home). On 2/3/16 at 4:48 p.m., another interview was conducted with OSM #4 (the social worker). OSM #4 stated she did not have a discussion with anyone regarding a mechanical lift prior to Resident #3's discharge. OSM #4 stated she talked to therapists, nurses and CNAs about Resident #3 and she thought the resident was at an independent level for operating her wheelchair. OSM #4 stated Resident #3 was not discharged with a wheelchair or bed side commode. OSM #4 stated the resident took a wheelchair from the facility but wasn't supposed to. OSM #4 stated she called a company to coordinate Resident #3's medical equipment after the resident was discharged. OSM #4 stated the therapy department didn't recommend Resident #3 to have a lift and stated she needed a sliding board and home health therapist. OSM #4 stated she remembered the resident saying she was fine	F 250		

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F 250	Continued From page 19 with a sliding board. On 2/3/16 at 5:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated during discharge plan meetings, staff talks about what residents need. ASM #2 stated she wasn't really involved in Resident #3's discharge. On 2/3/16 at 5:30 p.m., ASM #1, the administrator and ASM #2 were made aware of the above concern. The facility document titled "Clinical Services: Discharge Planning" documented in part, "Discharge planning is a collaborative effort between all departments to assist the patient in smoothly transitioning to the next desired care setting in their community or to a long term placement option. This is achieved through compliant patient centered care that focuses on the patients and their goals with every admission, care plan, therapy encounter and discharge..." The facility social worker job description documented, "Social Worker Responsibilities: Facilitates communication among resident/patient, family and interdisciplinary team members aimed at provision of risk/benefit information to support informed decision-making. Makes appropriate referrals to other consultants, community agencies, or Center departments in order to facilitate the resident's/patient's maximum use of resources, and to promote the resident's/patient's increased level of social functioning..." No further information was presented prior to exit.	F 250		

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F 250	Continued From page 20 * This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/multiplesclerosis.html	F 250		
F 309 SS=D	COMPLAINT DEFICIENCY 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to provide care and services to maintain residents' highest practicable level of well being for three of seven residents in the survey sample, Residents #4, #1 and #5. 1. The facility staff administered four units of *Novolog insulin (used to treat high blood sugar) to Resident #4 on 5/2/15 although there was an order to hold the insulin for a blood sugar less than 110 and the resident's blood sugar was 84 mg/dl (milligrams/deciliter). 2. Facility staff failed to monitor fluid restrictions for resident # 1. 3. The facility staff failed to follow the physician	F 309	F309 It is the practice of this facility to provide the necessary care and services to maintain residents' highest practicable level of wellbeing. I. Resident #1 and #4 have been discharged from the facility. The physician for resident #5 was notified regarding the blood sugar reading of 401. The physician will be notified of blood sugar readings outside of the parameters for resident #5. II. Residents receiving insulin with physician orders that indicate to hold and/or call MD if blood sugar reading is outside of the stated parameter and residents who have fluid restrictions have the potential to be affected. An audit of residents on insulin was	

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F 309	Continued From page 21 order to notify the physician if Resident #5's blood sugar went over 400. It went over 400 and the physician was not notified. The findings include: 1. Resident #4 was admitted to the facility on 4/8/15 with diagnoses that included but were not limited to: **pneumonia (lung infection), ***bipolar disorder (mental illness) and ****diabetes (high blood sugar). Resident #4 was discharged on 6/8/15. Resident #4's most recent MDS (minimum data set) (prior to discharge), a 14 day Medicare assessment with an ARD (assessment reference date) of 5/23/15, coded the resident as being cognitively intact. Section N documented Resident #4 received insulin injections seven out of the last seven days. Review of Resident #4's clinical record revealed a physician's order dated 4/16/15 to decrease the Novolog with breakfast to four units and to hold the medication for a blood sugar less than 110. Resident #4's May 2015 MAR (medication administration record) revealed four units of Novolog insulin was administered to Resident #4 with breakfast on 5/2/15 (as indicated by a nurse's initials and a check mark) although the resident's blood sugar was recorded as 84. Resident #4's comprehensive care plan with an initiation date of 4/9/15 documented, "Focus: Endocrine System related to insulin dependent diabetes...Interventions: Administer medication per physician orders..." The nurse responsible for administering Novolog	F 309	performed. Identified residents were reviewed to ensure appropriate parameters were in place. An audit of residents on fluid restrictions was performed to identify those residents. III. Licensed nursing staff were educated on following physician orders to hold medication and/or notifying the physician when the order indicates. Licensed nursing staff were educated on documenting the amount of fluids provided to residents having fluid restrictions to ensure proper fluid monitoring. IV. The Director of Nursing or her designee will audit documentation for residents having orders for fluid restriction to ensure appropriate documentation is in place. Residents on insulin will be audited to ensure the physician is notified when blood sugar readings are outside of the	

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F 309	Continued From page 22 with breakfast to Resident #4 on 5/2/15 was no longer employed at the facility. On 2/3/16 at 2:30 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked what should be done if a resident has a physician's order to administer four units of Novolog and to hold the insulin if the blood sugar is less than 110. RN #1 stated nurses check residents' blood sugars 30 minutes before meals. RN #1 stated if a resident's blood sugar was less than 110 then she wouldn't give the insulin. When asked what she would do if the resident's blood sugar was 84, RN #1 stated she would hold the insulin and give the resident something to drink or eat. On 2/3/16 at 5:00 p.m., an interview was conducted with ASM (administrative staff member) #2, (the director of nursing). ASM #2 was asked what a check mark with initials meant on the MAR. ASM #2 stated the check mark with initials on the MAR meant, "It's done." When asked to clarify what "it's done" meant, ASM #2 confirmed it meant the medication was administered. On 2/3/16 at 5:30 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above findings. The facility policy titled "Medication Administration: Injections" documented in part, "Procedure: 1. Open MAR (medication administration record) to patient record and review physician medication order against medication label..." No further information was presented prior to exit.	F 309	parameters as indicated on the physician order. These audits will occur 5 times a week for 2 weeks, 2 times a week for the following 2 weeks and then once per week for the following 4 weeks. Results of the audits will be reviewed by the Administrator and submitted to the QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits and or action plans V. 3/4/16	

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F 309	Continued From page 23 *This information was obtained from the website: http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3A1E73A2-3009-40D0-876C-B4CB2BE56FC5 **This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/pneumonia.html ***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=bipolar+disorder ****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 COMPLAINT DEFICIENCY Surveyor: Bresnock, Stephen T. 2. Resident # 1 was admitted to the facility on 2/10/15 with diagnoses that included but were not limited to: atrial fibrillation* (irregular heart beat), congestive heart failure* (a condition in which the heart can't pump enough blood to meet the body's needs) anxiety, hypertension* (high blood pressure), hyponatremia* (too much sodium), cerebral vascular accident* (stroke), coronary artery disease* (common type of heart disease), diabetes mellitus* (a disease in which your blood glucose, or blood sugar, levels are too high), prostate cancer, pacemaker, prostatectomy*	F 309		

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(removal of the prostate), gout* (a common, painful form of arthritis. It causes swollen, red, hot and stiff joints), insomnia and general weakness. * This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/003462.htm

The most recent MDS (minimum data set) an admission assessment, with an ARD (assessment reference date) of 2/17/15 coded the resident as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact. The resident was coded as requiring extensive assistance of one to two staff members for all of his activities of daily living.

The POS (physician order sheet) dated 2/1/2015 - 2/28/15 for Resident # 1 documented, "Controlled Lo (low) Sodium Cardiac Diet. Regular texture. LIMIT DAILY FLUID INTAKE TO 1.5 (one and a half) LITERS OR 48 OUNCES. Order Date: 02/10/2015. Start Date: 02/10/2015."

The physician's telephone order dated and signed by the physician on 2/14/15 for Resident # 1 documented, "Controlled diet. Regular texture. Fluid restriction 1.5 liters."

The POS (physician order sheet) dated Mar (March) 5, 2015 for Resident # 1 documented, "Controlled Diet. Regular texture. Fluid restriction 1.5 Liter. Order Date: 02/14/2015. Start Date: 02/14/2015. "

The TAR (treatment administration record) for Resident # 1 dated Feb (February) 2015 documented, "Limit Daily Fluid Intake to 1.5 Liters or 48 ounces every shift. D/C (discontinue)." The

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F 309	Continued From page 25 TAR revealed check marks and nurse's initials on the "Night" shift on 2/10/15, the "Days" shift on 2/11/15, 2/12/15 and 2/13/15, on the "Eveni" (evening) shifts on 2/11/15, 2/12/15 and 2/13/15." Further review of TAR dated 2/14/15 through 2/28/15 revealed staff failed to document that Resident # 1's fluid restriction was being monitored. Review of Resident # 1's TAR dated Mar (March) 2015 revealed that staff failed to document that Resident # 1's fluid restriction was being monitored. The nurse's "Progress Notes" dated 2/10/15 through 3/7/15 documented in part the following: · "2/16/2015 13:02 (1:02 p.m.) ...He is on 1.5L (liter) fluid restriction." · "2/16/2015 18:42 (6:42 p.m.) ...pt (patient) on fluid restriction per order." · "2/20/2015 18:03 (6:03 p.m.) ...pt on fluid restriction per order." · "2/22/2015 18:12 (6:12 p.m.) .... pt on fluid restriction per order." · "2/23/2015 03:23 (3:23 a.m.) ... remains on fluid restriction." · "2/23/2015 18:26 (6:26 p.m.) ... pt on fluid restriction per order." The "Diet Communication" form dated 2/14/15 for Resident # 1 documented, "1.5 liter fluid restriction." The "Nutritional Assessment" for Resident # 1 dated 2/15/2015 documented, "Nutrition Statement / Summary: ..Spoke with MD (medical doctor) on 2/13/15 agreeable to d/c (discontinue) Cardiac diet and low sodium restriction but continue 1.5 liter fluid restriction ..."	F 309		

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F 309	Continued From page 26 The facility's "Beverage Plan Worksheet" dated 2/11/15 for Resident # 1 documented, "Fluid restriction ordered 1.5 liter / (per) day per physicians orders. Nursing 780 cc (cubic centimeters), Dietary 720 CC. Nursing shift (7-3) [7:00 a.m. to 3:00 p.m.] 300 cc; (3-11) [3:00 p.m. to 11:00 p.m.] 300 cc; (11-7) [11:00 p.m. to 7:00 a.m.] 180 cc." Resident # 1's comprehensive care plan dated 2/11/15 documented, "Focus: Cardiac disease related to hypertension." Under "Interventions" it documented, "Dietary and/or fluid restrictions per physician order. Date initiated: 2/11/15." On 2/3/16 at 8:55 a.m. an interview was conducted with RN (registered nurse) # 1, unit manager regarding the procedure for residents on fluid restrictions. RN # 1 stated, "Dietary produces a sheet showing how much fluid a resident can have and how much is included in each meal. We (nursing) would offer the fluids and not keep extra in the resident's room to prevent them from taking more that the doctor ordered." When asked if the family had expressed any concerns regarding care RN # 1 stated, "Nothing was reported to me." On 2/3/16 at 9:50 a.m. an interview was conducted with OSM (other staff member) # 6, the dietician. When asked if she was familiar with Resident # 1 and the family OSM # 1 stated, "Yes. I met with the wife the day after admission and set up the fluid restriction sheet. There were never any concerns." On 2/3/16 at 11:30 a.m. an interview was conducted with RN # 2. When asked about	F 309		

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F 309	Continued From page 27 Resident # 1 RN # 2 stated, "I don't remember the resident." On 2/4/16 at 8:20 a.m. an interview was conducted with RN # 1, unit manager regarding the documentation of Resident # 1's fluid restrictions. After reviewing the TARs for Resident # 1 dated February and March 2015, RN # 1 stated that if the fluid restriction was not documented on Resident # 1's TAR it could be documented in the nurse's notes. RN # 1 was then asked to review the nurse's "Progress Notes" dated 2/10/15 through 3/7/15. When asked if Resident # 1 fluid restriction was documented in the nurse's notes, RN # 1 was able to identify documentation on 2/16/2015 at 13:02 (1:02 p.m.), 2/16/2015 at 18:42 (6:42 p.m.), 2/20/2015 at 18:03 (6:03 p.m.), 2/22/2015 at 18:12 (6:12 p.m.), 2/23/2015 at 03:23 (3:23 a.m.) and on 2/23/2015 at 18:26 (6:26 p.m.). RN # 1 further stated that the nurses supervise how much fluid the resident gets and it should be documented on the TAR that the fluid restriction was done and the amount of fluid the resident gets each shift. When asked what would be the purpose of fluid restrictions RN # 1 stated, "It is so the resident doesn't get more than they are supposed to get. The nurse is supposed to monitor how much fluid the resident took in the nurse's notes." When asked if the process she described was followed for Resident # 1, RN # 1 stated, "Not really." When asked about the missing documentation of Resident # 1's fluid restriction, RN # 1 stated, "If it wasn't documented I can't say it was being done." On 2/4/16 at approximately 8:25 a.m. an interview was conducted with RN # 4 regarding the procedure of a resident on fluid restrictions. RN #	F 309		

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F 309	Continued From page 28 4 stated that the dietician develops a worksheet and it's put with the 24 hour report and nursing tell the CNAs (certified nursing assistants) how much the resident gets. When asked where it is documented RN # 4 stated in the nurse's notes and in the 24 hour report. When asked how nursing monitors the amount of fluids the resident takes, RN # 4 stated, "We monitor the trays with fluids." When asked who monitors the amount of fluid a resident took in a 24 hors period, RN # 4 stated, "The manager and the dietician." On 2/4/16 at approximately 8:32 a.m. an interview was conducted with RN # 2 regarding the procedure of a resident on fluid restrictions. RN # 2 stated, "Every shift we put fluids in the room. Document if the resident drinks that shift. The total of the day is on the 24 hour report. The intake is documented in the progress notes." When asked who monitors the resident's fluid intake RN # 2 stated the nursing manager. On 2/3/16 at 5:30 p.m. ASM (administrative staff member) # 1, administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. COMPLAINT DEFICIENCY 3. Resident #5 was admitted to the facility on 10/14/12 with a recent readmission on 12/30/15 with diagnoses that included but were not limited to: congestive heart failure, gastroesophageal reflux disease, glaucoma, anemia, high blood pressure, peripheral vascular disease, and diabetes.	F 309		

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F 309	Continued From page 29 The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 1/11/16, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or two people for all of his activities of daily living. In Section N - Medications, the resident was coded as having received insulin injections fur the past seven days of the look back period. The physician order dated, 12/31/15, documented in part: "Sliding scale insulin with Novolog Solution 100 units/ML (units per milliliter) ...if BS (blood sugar) 401 + (plus) = (equals) give 10 units; If BS > (greater than) 400, give insulin and call doctor, subcutaneously before meals and at bedtime for dm (diabetes mellitus)." The Medication Administration Record (MAR) for January 2016 documented in part: "Sliding scale insulin with Novolog solution 100 units/ML (units per milliliter) ...if BS (blood sugar) 401 + = give 10 units; If BS > (greater than) 400, give insulin and call doctor, subcutaneously before meals and at bedtime for dm (diabetes mellitus)." On 1/19/16, the 11:00 a.m. blood sugar was documented as 401. Ten units of insulin was documented as administered. Review of the Progress Notes, dated 1/19/16, did not reveal any documentation the physician was notified of Resident #5's 401 mg/dl (milligram/deciliter) blood sugar reading as ordered. The comprehensive care plan, dated, 6/10/13	F 309		

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with a revision on 12/27/15, documented, "Focus: Endocrine System related to; Insulin Dependent Diabetes." The "Interventions" documented, "Administer medications per physician orders. Report symptoms of hyperglycemia: excessive thirst/urination, hunger, weakness, N/V (nausea/vomiting) acetone breath."

An interview was conducted with LPN (licensed practical nurse) #3 on 2/3/16 at 4:06 p.m. regarding sliding scale insulin orders with documented parameters to call the physician if the blood sugar is over 400. When asked what the nurse would do if the blood sugar was 401, LPN #3 stated, "I'd call the doctor and let him know." When asked where the call to the physician was documented, LPN #3 stated, "In the progress notes."

An interview was conducted with RN (registered nurse) #6 on 2/3/16 at 4:15 p.m., regarding sliding scale insulin orders with documented parameters to call the physician if the blood sugar is over 400. When asked what the nurse would do if the blood sugar was 401, RN #6 stated, "I have to call the doctor and follow what orders he may give me." When asked where the call to the physician is documented, RN #6 stated, "I have to write a note in the progress notes."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 2/3/16 at 4:28 p.m. When asked if the physician wrote an order to be notified if the resident's blood sugar is less than 70 or over 400, what is expected of the nurse if the blood sugar is 401, ASM #2 stated, "They should have called the doctor."

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F 309	Continued From page 31 The facility policy, "Glucose Blood Monitoring (Finger Stick Blood Sugar)" documented, "Suggested Documentation: Unusual observations and/or complaints and subsequent interventions including communications with physician." In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. ASM #1, (administrator), ASM #2, (director of nursing) and ASM #3, (the quality assurance coordinator), were made aware of the above concern on 2/3/16 at 4:30 p.m. No further information was provided prior to exit. (1) Nurse's Manual of Laboratory and Diagnostic Tests; Bonita Cavanaugh Fourth Edition page 107.	F 309		
F 314 SS=D	COMPLAINT DEFICIENCY 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314	F314 It is the practice of this facility to assess and monitor pressure ulcers. I. Resident #2 has been discharged from the facility.	

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F 314	Continued From page 32 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to assess and monitor a pressure ulcer for one of seven residents in the survey sample, Resident #2. Resident #2 was identified as having an open area on his sacrum; treatment was applied but no further assessment or orders related to the pressure ulcer were documented. The findings include: Resident #2 was admitted to the facility on 5/19/15 with a readmission on 6/8/15 with diagnoses that included but were not limited to: heart failure, high blood pressure, lung cancer with metastasis to the bone and brain, chronic venous insufficiency, stasis dermatitis and shortness of breath. The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 6/15/15, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one to two staff members	F 314	II. Residents admitted to the facility with open areas have the potential to be affected. III. Licensed nursing staff were educated on the facility's skin practice guidelines which includes documentation of noted open areas, second skin assessment and notification to the wound team. IV. The admission assessment and 2nd skin note will be audited by the Director of Nursing or her designee to ensure proper documentation and interventions for residents admitted with open skin areas. This audit will occur 5 times per week for 2 weeks then 2 times per week for 2 weeks and then weekly for 4 weeks to ensure compliance. Results of the audits will be reviewed by the Administrator and submitted to the QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits and or action	

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F 314	Continued From page 33 for all of his activities of daily living including moving in the bed and transfers. In Section M - Skin Conditions, the resident was coded as being at risk for developing pressure ulcers but did not have any pressure ulcers. The hospital discharge summary dated 6/8/15, documented, "Discharge Instructions: 10) Sacral skin tear: continue wound care, this is less than a centimeter and superficial." The "Patient Admission Readmission Screen" dated, 6/8/15, documented, "Z. Skin: blanchable and nonblanchable ** redness noted to sacrum, small open area*** observed, no drainage, borders intact, pink tissue observed. Mepilex applied." The Braden Score * documented on the form stated, "17." Indicating the resident was at "low risk for skin breakdown." * A Braden Score is a valid tool used to assess a resident for the risk of developing pressure ulcers. The total score ranges from 6 to 23; a lower total score indicates a higher risk for pressure ulcer development. The Braden Scale is highly reliable when used to identify clients at greatest risk for pressure ulcers." (2) **NON-BLANCHABLE - Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device. Stage 1 pressure ulcer. (3) ***A stage II pressure ulcer is described as partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough (non viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture). May also present as an	F 314	plans V. 3/4/16	

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F 314	Continued From page 34 intact or open/ruptured blister. (3) Mepilex is foam dressing suitable for a wide range of wounds like venous leg ulcers, pressure ulcers, or diabetic ulcers. Mepilex® minimizes pain and wound or skin damage at dressing change. (1) The progress note dated, 6/8/15 at 21:54 (9:54 p.m.) documented, "Blanchable and nonblanchable redness noted to sacrum, small open area observed, no draig=nage (sic) borders intact, pink tissue observed, Mepilex applied." Review of the physician orders did not reveal an order for the Mepilex or any treatment for the pressure ulcer on the Resident #2's sacrum. Further review of the progress notes did not reveal any documentation of the open area on the sacrum of Resident #2. The comprehensive care plan dated, 5/20/15, documented, "Focus: At risk for alteration in skin integrity related to impaired mobility." The "Interventions" documented, "Barrier cream to peri area/buttocks as needed. Encourage to reposition as needed, use assistive devices as needed. Observe skin condition with ADL (activities of daily living) care daily; report abnormalities. Provide preventative skin care routinely and prn (as needed)." A "Skin Worksheet" dated 6/11/15, documented, "Shower given, no skin issues." On 2/3/16 at 1:09 p.m. ASM (administrative staff member) #2, the director of nursing, was asked if the facility had any wound documentation on the	F 314		

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area documented in the progress notes and on the skin assessment on 6/8/15. ASM #2 stated, "No, we don't have any."

An interview was conducted with LPN (licensed practical nurse) #4 on 2/3/16 at 1:20 p.m. When asked the process for skin assessments and treatment of pressure ulcers, LPN #4 stated, "All new patients get a skin assessment, head to toe, by the admitting nurse. The next day either a nurse or the wound nurse goes in and does a second assessment." When asked where the second assessment is documented, "LPN #4 stated, "The nurse will document it in the progress note." LPN #4 further stated, "A skin assessment is normally done every week on Wednesdays. The CNAs (certified nursing assistants) do a skin sheet when they give the resident a shower too."

A telephone interview was conducted with LPN #1, the nurse who completed the skin assessment and nurses' note on 6/8/15, on 2/2/16 at 1:37 p.m. LPN #1's nursing note and skin assessment were read to her over the phone. When asked what the word nonblanchable meant, LPN #1 stated, "Nonblanchable is a stage 1 pressure ulcer." When asked what open area means, LPN #1 stated, "If the area is open, then it's a stage 2 pressure ulcer." When asked what happens after she has assessed the resident's skin and applied the Mepilex, LPN #1 stated, "I put it on the 24 hour report sheet that the wound nurse needs to see resident for appropriate treatment orders."

The 24 hours report sheet dated, 6/8/15, documented the resident as a readmission. There was no documentation of the need for

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F 314	Continued From page 36 wound care. An interview was conducted with ASM #4, the nurse practitioner, on 2/3/16 at 1:51 p.m. ASM #4 was asked to review her progress notes of 6/9/15. Once reviewed, ASM #4 was asked if she looked at Resident #2's sacral area. ASM #4 stated, "I don't believe I did. If there was a concern then I would have looked at it but I was not aware of any skin concerns. The staff normally tells me of any skin issues in the morning meeting. I then go with the nurse and look at the skin." When asked the process for skin assessments, ASM #4 stated, "The admitting nurse assesses the resident and completes a skin assessment. The second day of admission the wound nurse and manager (unit manager) go and do a second skin assessment. They tell me everything." ASM #4 was asked to read the progress note of 6/8/15. ASM #4 stated, "I would have been notified of any wound. Since my note doesn't mention anything I would believe I was not notified." An interview was conducted with RN (registered nurse) #5, the wound nurse, on 2/2/16 at 2:17 p.m., when asked the process for skin assessments at the facility, RN #5 stated, "The admitting nurse does a head to toe assessment at the time of admission. The next day, I or another nurse does a second skin assessment. If there are any skin assessment abnormalities, we call the doctor for orders." When asked where the second skin assessment is documented, RN #5 stated, "The nurse doing the second assessment should write a progress note." When asked if she was present on 6/8/15 or 6/9/15, RN #5 stated, "No, I was not here that week. I was in class for my wound care	F 314		

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F 314	Continued From page 37 certification." An interview was conducted with ASM #2, the director of nursing, on 2/3/16 at 4:35 p.m. ASM #2 was asked for any documentation evidencing a second assessment of Resident #2 ' s sacral wounds were completed on 6/9/15. ASM #2 stated, "The unit manager who was here at that time is no longer here. I am sure she did the assessment but didn't document it. On the shower sheet on 6/11/15 there was no skin issues seen by the CNA. All CNAs apply a protective cream after each incontinence care. This resident was ambulatory and continent." When asked if there have been an assessment and monitoring of the area noted on 6/8/15 by a licensed nurse and documentation of this assessment and monitoring, ASM #2 stated, "I'm certain it was done but she's no longer here and it's a documentation issue." The ASM #1, the administrator, ASM #2 and ASM #3, Quality Assurance Coordinator, were made aware of these findings. The facility policy, "Skin Practice Guide" documented, "Phase 1: Complete the Nursing Admission Evaluation including a head-to-toe full body audit to identify the presence of pressure ulcers or other skin alterations. Document findings on the Nursing Admission Evaluation. The Nursing Admission Evaluation also contains the initial Braden Scale...Alteration in Skin Integrity: If alteration skin integrity is identified on admission, a designated member of the wound team evaluates the status of the wound (ideally within 24 hours of admission) and collaborates with the licensed nurse, physician or advanced practice nurse to determine the type of alteration	F 314		

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F 314	Continued From page 38 present. Treatment orders are obtained, noted and initiated as ordered with the identification of alteration in skin integrity...If a pressure ulcer is identified, a PUSH tool is initiated by a member of the wound team, for each site identified. A comprehensive evaluation is also completed and documented in the patient's clinical record and may include, but not limited to: depth, appearance of surrounding skin, presence and location of tunneling and, or undermining, evidence of infection or pain....Upon completion of the wound evaluation, the physician/family/responsible party are notified and the initial plan of care is developed and initiated to meet he patient's individual needs. Interventions may include, but are not limited to: support surfaces/specialty mattress, turning and positioning, incontinence management, referral to dietician, pain management, referral to dietician, pain management, referral to therapy and treatment as ordered." Treatment of Pressure Ulcers, U.S. Department of Health and Human Services, Publication Number 15, documents, in part: " The assessment of an individual with a pressure ulcer is the basis for planning treatment, evaluating treatment effects, and communicating with other caregivers. Initially, the clinician should determine the location, stage, and size of the pressure ulcer. Accurate staging and description of pressure sores is a perquisite to the development and implementation of appropriate, effective treatment protocols and to effective, ongoing monitoring of tissue healing. " "Use devices that totally relieve pressure on the heels, most commonly by raising the heels off of the bed ...."And also," ....individuals in bed should have a care plan that includes the use of devices that	F 314		

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F 314	Continued From page 39 totally relieve pressure on the heels, most commonly by raising the heels off of the bed." According to Lippincott Manual of Nursing Practice, Eighth Edition, part 2, unit 1, section 9, special health problems of the older adult, page 187, "nursing and patient care considerations in prevention and healing of pressure ulcers; relieve the pressure by: reposition every two hours, using special devices to cushion specific areas such as the heels." (1) http://www.molnlycke.us/advanced-wound-care-products/foam-dressings/mepilex/#confirm (2) Perry and Potter; Fundamentals of Nursing, 6th edition page 1495. (3) Centers for Medicare & Medicaid Services; Long-Term Care Facility Resident Assessment Instrument User's Manual; Version 3.0 July 2010, pages M-15, M-18, M-2.	F 314		
F 329 SS=D	COMPLAINT DEFICIENCY 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329	F329 It is the practice of this facility to ensure the drug regimen is free from unnecessary drugs. I. Resident # 4 has been discharged from the facility. II. Residents prescribed insulin with parameters used to determine administration of the medication	

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F 329	Continued From page 40 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to ensure a resident was free from unnecessary medications for one of seven residents in the survey sample, Resident #4. The facility staff administered four units of *Novolog insulin (used to treat high blood sugar) to Resident #4 on 5/2/15 although there was an order to hold the insulin for a blood sugar less than 110 and the resident's blood sugar was 84. The findings include: Resident #4 was admitted to the facility on 4/8/15 with diagnoses that included but were not limited to: **pneumonia (lung infection), ***bipolar disorder (mental illness) and ****diabetes (high blood sugar). Resident #4 was discharged on 6/8/15. Resident #4's most recent MDS	F 329	have the potential to be affected. An audit of residents receiving insulin was conducted to ensure appropriate physician ordered parameters were included with the order on the medication administration record (MAR) III. Education was provided to Licensed Nurses regarding following physician orders and ensuring parameters are followed when administering insulin The Director of Nursing or her designee will audit the MAR of patients receiving insulin 5 times weekly for 2 weeks and weekly thereafter for an addition 2 months to ensure parameters are followed as ordered and documented. IV. Results of the audits will be reviewed by the Administrator and submitted to the facility's QAPI committee for review and action as appropriate. The QAPI committee will determine the need for further audits or action plans.	

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F 329	Continued From page 41 (minimum data set) (prior to discharge), a 14 day Medicare assessment with an ARD (assessment reference date) of 5/23/15, coded the resident as being cognitively intact. Section N documented Resident #4 received insulin injections seven out of the last seven days. Review of Resident #4's clinical record revealed a physician's order dated 4/16/15 to decrease the Novolog with breakfast to four units and to hold the medication for a blood sugar less than 110. Resident #4's May 2015 MAR (medication administration record) revealed four units of Novolog insulin was administered to Resident #4 with breakfast on 5/2/15 (as indicated by a nurse's initials and a check mark) although the resident's blood sugar was recorded as 84. Resident #4's comprehensive care plan with an initiation date of 4/9/15 documented, "Focus: Endocrine System related to insulin dependent diabetes...Interventions: Administer medication per physician orders..." The nurse responsible for administering Novolog with breakfast to Resident #4 on 5/2/15 was no longer employed at the facility. On 2/3/16 at 2:30 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked what should be done if a resident has a physician's order to administer four units of Novolog and to hold if the blood sugar is less than 110. RN #1 stated nurses check residents' blood sugars 30 minutes before meals. RN #1 stated if a resident's blood sugar was less than 110 then she wouldn't give the insulin. When asked what she would do if the resident's blood	F 329	V. 3/4/16	

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F 329	Continued From page 42 sugar was 84, RN #1 stated she would hold the insulin and give the resident something to drink or eat. On 2/3/16 at 5:00 p.m., an interview was conducted with ASM (administrative staff member) #2, (the director of nursing). ASM #2 was asked what a check mark with initials meant on the MAR. ASM #2 stated the check mark with initials on the MAR meant, "It's done." When asked to clarify what "it's done" meant, ASM #2 confirmed it meant the medication was administered. On 2/3/16 at 5:30 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above findings. On 2/4/16 at 8:15 a.m. a policy regarding unnecessary medications was requested. On 2/4/16 at 8:35 a.m., ASM #2 stated the facility did not have the requested policy. No further information was presented prior to exit. *This information was obtained from the website: http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3A1E73A2-3009-40D0-876C-B4CB2BE56FC5 **This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/pneumonia.html ***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=bipolar+disorder	F 329		

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F 329	Continued From page 43 *****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 COMPLAINT DEFICIENCY	F 329		