COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

March 30, 2017

Mr. Tristan Lester, Administrator
Manorcare Health Services-Fair Oaks
12475 Lee Jackson Memorial Highway
Fairfax, VA 22033-2803

RE: Manorcare Health Services-Fair Oaks
Provider Number 495217

Dear Mr. Lester:

An unannounced standard survey, ending March 23, 2017, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Two complaints were investigated during the survey and were unsubstantiated, with no deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of F), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Wietske G Weigel-Delano, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at "http://www.vdh.state.va.us/OLC/longtermcare/".

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).

- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,

- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: "http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Wietske G Weigel-Delano, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman
Joann Atkins, Dmas (Sent Electronically)

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 03/23/2017

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	F 000		

An unannounced Medicare/Medicaid standard survey was conducted from 3/21/17 through 3/23/17. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow.

The census in this 150 certified bed facility was 132 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #1 through # 21) and five closed record reviews (Residents # 22 through # 26).

F 251 SS=E	483.70(p)(1)(2) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS	F 251		

(p) Social worker.

Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:

(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and

(2) One year of supervised social work experience in a health care setting working directly with individuals
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility policy review, it was determined that facility staff failed to provide full time social services to the residents.

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 this plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated.

F 251 – Qualifications of Social Worker > 120 Beds

It is the practice of the facility to employ a qualified social worker on a full-time basis. A qualified social worker is: (1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling and psychology; and (2) One year of supervised social work experience in a health care setting working directly with individuals.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4/17/17

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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Facility staff failed to provide social services to the residents from 2/10/17 through 3/21/17.

The findings include:

Review of the 2/16/17 Resident council meeting minutes documented, "(Name of social worker left, no social services for right now. He (administrator) will be dealing with discharge planning, DAME (durable medical equipment), etc...."

An interview was conducted on 3/22/17 at 10:20 a.m. with ASM (administrative staff member) #1, the administrator. ASM #1 was asked when the social services director left the facility. ASM #1 stated, "Since February 10th (2017)." When asked if there was any staff in the social services department, ASM #1 stated, "No." ASM #1 stated, "We've been actively looking, we had two offers out (but they were declined). We have a social worker who comes on Mondays to help out." When asked who was doing discharge planning, ASM #1 stated that he was. When asked if he had the credentials needed to act in the place of the social service director, ASM #1 stated, "No. I don't." ASM #1 was made aware of the concern at this time.

Review of the facility's job description titled, "SOCIAL SERVICES COORDINATOR" documented, "Job Summary Responsiblility, to provide medically related social work services so that each patient may attain or maintain the highest practicable level of physical, mental and psychosocial well-being. Education ...Bachelor's Degree in Social Work or a Bachelor's Degree in Human Services field, including but not limited to

CRITERIA ONE:
From 2/10/2017 through 3/21/2017 social services were being provided by interdisciplinary team to the residents and 8 hours a week of social service assistance was being provided by the social worker from a sister facility.

CRITERIA TWO:
Any and all residents have the potential to be affected by this alleged deficient practice.

CRITERIA THREE:
The interdisciplinary team will be educated on ensuring that full time social services will be provided by the facility to the residents.

CRITERIA FOUR:
The Administrator or designee will audit five resident's charts daily for five days, weekly for three weeks and then monthly for two months for full time social services.
Results of the audit will be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator or designee for further review and follow up recommendations.

CRITERIA FIVE:
The facility's alleged date of compliance is 5/5/2017.

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F 251	Continued From page 2 Sociology, Special Education, Rehabilitation Counseling and Psychology; Current License required (For Centers with more than 120 beds). Experience For Centers with more than 120 beds: One year of supervised Social Work experience in a health care setting working directly with geriatric individuals." No further information was provided prior to exit.	F 251		
F 252 SS=D	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced	F 252	**F 252 – Safe/Clean/Comfortable/ Homelike Environment** It is the practice of the facility to provide residents with a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	

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by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to provide a clean and comfortable home-like environment in seven of 100 resident rooms.

The facility staff failed to maintain resident room #s 135, 216, 231, 234, 235, 237 and 238 in a clean and homelike environment.

The findings include:

During the initial tour on 3/21/17 at 11:40 a.m. the following observations were made of the following resident rooms and bathrooms;

- In the bathroom of Room 135, wallpaper was observed peeling off of the bathroom wall in three areas and on the outside of the bathroom door, the bottom of the door was observed with a hole measuring approximately, 3 x 1 inches.
- In Room 216 - wall paper was observed peeling off the wall on the wall beside the bathroom door as you entered into the room.
- In the bathroom of Room 231, the paper towel dispenser attached to the right side wall upon entering the bathroom, was observed hanging off of the wall. On the lower part of the right wall a hole was observed in the drywall measuring 4 x 1 inches.
- In the bathroom of Room 234, a large round hole was observed in the back of the bathroom door, close to the bottom of the door measuring approximately 4 x 1 inches.
- In the bathroom of Room 235 bathroom, the linoleum on the floor of the bathroom was observed rolling up on the right side of the bathroom beside the sink. The wallpaper was

CRITERIA ONE:
The wallpaper and door in the bathroom in room 135 has been repaired. The wallpaper in room 216 has been repaired. The paper towel dispenser and wall in room 231 has been repaired. The bathroom door in room 234 has been repaired. The bathroom floor and wallpaper in room 235 has been repaired. The wallpaper in the bathroom of room 237 has been repaired. The wallpaper across from the B bed in room 238 has been repaired.

CRITERIA TWO:
Any and all residents have the potential to be affected by this alleged deficient practice.

CRITERIA THREE:
The Maintenance Director and Maintenance Assistant will be educated on the facility providing residents with a safe, clean, comfortable and homelike environment.
The Nursing staff will be educated on entering work orders into the TELS system.

CRITERIA FOUR:
The Administrator or designee will audit five resident rooms daily for five days, weekly for three weeks and then monthly for two months for the facility providing residents with a safe, clean, comfortable and homelike environment.

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observed with multiple areas of discoloration.
- In the bathroom of Room 237, the right corner of the bathroom, the wallpaper was observed peeling off of the wall, exposing dry wall.
- In Room 238, wallpaper was observed pulled off of the wall across from the B bed in the room.

On 3/23/17 at 7:40 a.m. a tour of the facility was conducted with OSM (other staff member) #7, the maintenance director. All rooms identified above with areas of concern were inspected and verified at this time. OSM #7 stated that he was aware that the wallpaper needed to be replaced in many rooms and that the materials had been purchased and delivered but he had been unable to "get to it."

Following the tour of the facility an interview was conducted with OSM #7 at approximately 8:30 a.m. OSM #7 was asked whether or not the condition of the rooms inspected was acceptable. OSM #7 stated that the rooms were below his "standard." OSM #7 was asked if the rooms were homelike when considering the areas of concern. OSM #7 stated that he would not want that in his home. OSM #7 was asked about the process for maintenance. OSM #7 stated that the nursing staff would enter the area of concern in their "TELS" system, an online system that provided an immediate alert to his phone. When asked if he had received any such alerts regarding the rooms toured, OSM #7 stated that he had not. OSM #7 was asked to provide policies regarding maintenance and the "TELS" system used to identify maintenance concerns.

On 3/23/17 at approximately 9:45 a.m. ASM (administrative staff member) #1, the administrator brought a document to this surveyor

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Results of the audit will be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator or designee for further review and follow up recommendations.

CRITERIA FIVE:
The facility's alleged date of compliance is 5/5/2017.

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F 252	Continued From page 5 that was titled "POC (plan of care): TELS - Quick Reference Guide" that included, in part, the following documentation: "WHAT. TELS allows a CNA (certified nursing assistant) to initiate a maintanance (sic) work order within the building. WHEN. When a maintenance (sic) issue arises, use TELS to initiate a work order to alert the Maintanance (sic) staff to the problem." ASM #1 was made aware of the concerns at this time, and no other policies or documents were provided prior to the end of the survey process.	F 252		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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	F 278	**F 278 – Assessment Accuracy/ Coordination/Certified** It is the practice of the facility that the assessment must accurately reflect the resident's status. **CRITERIA ONE:** Resident #4's annual MDS has been modified and resubmitted. Resident #2's quarterly MDS has been modified and resubmitted. Resident #6's quarterly MDS has been modified and resubmitted. **CRITERIA TWO:** Any and all residents have the potential to be affected by this alleged deficient practice.	

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assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for three of 26 residents in the survey sample, Resident #s 4, 2 and 6.

1. The facility staff failed to accurately code bladder incontinence on Resident #4's annual MDS assessment with an ARD (assessment reference date) of 4/20/16.

2. The facility staff incorrectly coded Resident #2 as having impairments to her bilateral upper extremities on her quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/20/17.

3. The facility staff failed to accurately code the amount of assistance Resident #6 required with eating on the resident's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/5/17.

The findings include:

1. The facility staff failed to accurately code bladder incontinence on Resident #4's annual

CRITERIA THREE:
MDS and nursing staff will be re-educated on assessing and accurately coding resident's MDS.
C.N.A.s will be re-educated on accurate ADL coding.

CRITERIA FOUR:
The Administrator or designee will audit five resident's sections H, G0400 and G of the MDS for accurate assessment and coding daily for five days, weekly for three weeks and then monthly for two months.
Results of the audit will be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator or designee for further review and follow up recommendations.

CRITERIA FIVE:
The facility's alleged date of compliance is 5/5/2017.

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MDS assessment with an ARD (assessment reference date) of 4/20/16.

Resident #4 was admitted to the facility on 4/13/16 with a readmission date of 3/10/17 with diagnoses that included, but were not limited to, anemia (a low red blood cell count), obstructive uropathy [1] (a condition where urine cannot drain into the bladder from the kidneys), dementia and failure to thrive.

Resident #4's most recent MDS was a quarterly assessment with an ARD of 1/21/17. Resident #4 was coded on her BIMS (brief interview of mental status) as having scored two out of a possible score of 15, indicating that Resident #4 was severely cognitively impaired with daily decision making. Resident #4 was also coded as having an indwelling catheter (a tube inserted into the bladder to drain urine).

A review of Resident #4's annual MDS assessment with an ARD of 4/20/16 revealed that Resident #4 was coded in Section H, Bladder and Bowel, as having an indwelling catheter and under urinary continence selected as "3. Always incontinent"

A review of Resident #4's comprehensive care plan dated 4/14/16 revealed, in part, the following documentation; "Focus. Use of indwelling urinary catheter needed due to urinary retention secondary to obstructive uropathy. Date Initiated: 4/14/2016."

On 3/22/17 at 2:30 p.m. an interview was conducted with RN (registered nurse) #3, the MDS coordinator. RN #3 was asked to review Resident #4's MDS assessment with an ARD of

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4/20/16, specifically Section H. RN #3 reviewed and stated that the resident (Resident #4) was coded as having a catheter and should not have been also coded as being incontinent, "She (Resident #4) should have been coded as a 9 (nine) not rated. The MDS is incorrectly coded." RN #3 was asked what she used as a reference tool when completing the MDS assessments, RN #3 stated that she used the RAI (resident assessment instrument) manual.

The RAI manual documents, in part, the following information related to completion of Section H, Bladder and Bowel;

"Coding Instructions
· Code 0, always continent: if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence.
· Code 1, occasionally incontinent: if during the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime.
· Code 2, frequently incontinent: if during the 7-day look-back period, the resident was incontinent of urine during seven or more episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime.
· Code 3, always incontinent: if during the 7-day look-back period, the resident had no continent voids.
· Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine

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output) for the entire 7 days."

An end of day meeting was conducted on 3/22/17 at 5:20 p.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and RN #1, the assistant director of nursing. The administrative staff were made aware of the above findings.

No further information was provided prior to the end of the survey process.

[1] This information was obtained from the following website;
https://medlineplus.gov/ency/article/000507.htm

2. The facility staff incorrectly coded Resident #2 as having impairments to her bilateral upper extremities on her quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/20/17.

Resident #2 was admitted to the facility on 4/11/14 with diagnoses that included but were not limited to bipolar disorder, repeated UTIs (urinary tract infections), falls, major depressive disorder with manic episodes, anorexia, anemia, and vitamin D deficiency. Resident #2's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/20/17. Resident #2 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #2 was coded as requiring extensive assistance from staff with transfers, dressing, and personal

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hygiene; and total dependence on staff with locomotion and bathing. Resident #2 was coded as needing limited assistance with one staff member with eating.

Review of Resident #2's quarterly MDS with an ARD of 1/20/17, documented the following under Section G0400. Functional Status: "Functional Limitation in Range of Motion... Code for limitation that interfered with daily functions or placed resident at risk of injury Coding: 0. No impairment, 1. Impairment on one side, 2. Impairment on both sides." A "2" was coded under "A. Upper Extremity" indicating Resident #2 had impairments to both upper extremities.

On 3/21/16 at 3:30 p.m., an observation was made of Resident #2. She picked up a cup of liquid with her left arm and hand and took a sip and placed the cup back down on her bedside table. No impairment was identified to her left upper extremity.

On 3/21/16 at 3:35 p.m., further observation was made of Resident #2. She picked up the cup of liquid with her right arm and hand and took a sip and placed the cup back down on her bedside table. No impairment was identified to her right upper extremity.

Review of Resident #2's nursing notes from December 2016 until March 2017 failed to reveal any impairment to Resident #2's upper extremities.

On 3/22/17 at 1:21 p.m., an interview was conducted with LPN (licensed practical nurse) #2, a nurse who frequently works with Resident #2. LPN #2 stated that Resident #2 had no

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impairments to her upper extremities. LPN #2 could not recall Resident #2 ever having impairments to her upper extremities.

On 3/22/17 at 2:31 p.m., an interview was conducted with RN (registered nurse) #3, the MDS nurse. She could not identify a reason why Resident #2's quarterly MDS assessment with an ARD (assessment reference date) of 1/20/17 coded her as having upper extremity impairments. RN #3 stated that the nurse who completed Resident #2's MDS assessment was filling in during January and is no longer at the facility. On 3/22/17 at 2:40 p.m., RN #3 stated, "I just saw (Name of Resident #2) and she can move her upper extremities. It had to have been a miscoding." RN #3 stated that she uses the RAI manual as a reference when completing the MDS.

On 3/22/17 at 5:24 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3 the corporate nurse were made aware of the above findings.

Review of the Resident Assessment Instrument Manual 3.0 documents the following:

"Coding Instructions for G0400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); G0400B, Lower Extremity (Hip, Knee, Ankle, Foot)

· Code 0, no impairment: if resident has full functional range of motion on the right and left side of upper/lower extremities.
· Code 1, impairment on one side: if resident has an upper and/or lower extremity impairment on one side that interferes with daily functioning or

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places the resident at risk of injury.
· Code 2, impairment on both sides: if resident has an upper and/or lower extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury.

Examples for G0400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); G0400B, Lower Extremity (Hip, Knee, Ankle, Foot)
1. The resident can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. She is able to perform grooming activities (e.g. brush teeth, comb her hair) with her right upper extremity, and is also able to pivot to her wheelchair with the assist of one person. She is, however, unable to voluntarily move her left side (limited arm, hand and leg motion) as she has a flaccid left hemiparesis from a prior stroke.

Coding: G0400A would be coded 1, upper extremity impairment on one side. G0400B would be coded 1, lower extremity impairment on one side.

Rationale: Impairment due to left hemiparesis affects both upper and lower extremities on one side. Even though this resident has limited ROM that impairs function on the left side, as indicated above, the resident can perform ROM fully on the right side. Even though there is impairment on one side, the facility should always attempt to provide the resident with assistive devices or physical assistance that allows for the resident to be as independent as possible.

2. The resident had shoulder surgery and can't brush her hair or raise her right arm above her head. The resident has no impairment of the

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lower extremities.

Coding: G0400A would be coded 1, upper extremity impairment on one side. G0400B would be coded 0, no impairment.
Rationale: Impairment due to shoulder surgery affects only one side of her upper extremities."

No further information was presented prior to exit.

3. The facility staff failed to accurately code the amount of assistance Resident #6 required with eating on the resident's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/5/17.

Resident #6 was admitted to the facility on 9/1/15. Resident #6's diagnoses included but were not limited to: high blood pressure, dementia (1) and heart disease. Resident #6's most recent MDS, a quarterly assessment with an ARD of 2/5/17, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded the resident as requiring extensive assistance of two or more staff with eating as documented as "3" in section G0110 column one and "3" in section G0110 column two.

On 3/22/17 at approximately 9:34 a.m., Resident #6 was observed feeding himself after his breakfast tray was served.

On 3/22/17 at 11:10 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated Resident #6 feeds himself but sometimes needs staff to prepare his tray and talk to him to encourage eating.

On 3/22/17 at 11:42 a.m., an interview was

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conducted with RN (registered nurse) #3 (MDS coordinator). RN #3 was informed on the above observation and was asked to explain why Resident #6 was coded on the MDS as requiring extensive assistance of two or more staff with eating. RN #3 stated she would have to look into this because the MDS coordinator who completed the MDS worked as needed.

On 3/22/17 at 11:47 a.m., RN #3 stated the eating portion of section G on Resident #6's MDS was probably an error. RN #3 stated she went to see the resident and interviewed activities and nursing staff. RN #3 stated Resident #6 could feed himself with set up and she would modify the MDS. RN #3 stated she references the RAI (resident assessment manual) when completing MDS assessments.

On 3/22/17 at 5:40 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the quality assurance consultant) and RN (registered nurse) #1 (the assistant director of nursing) were made aware of the above findings.

The CMS (Centers for Medicare & Medicaid Services) RAI manual documented,

"G0110: Activities of Daily Living (ADL) Assistance...A. Eating: how resident eats and drinks, regardless of skill....Coding Instructions...Coding Instructions for G0110, Column 1, ADL Self-Performance
-Code 0, independent: if resident completed activity with no help or oversight every time during the 7-day look-back period and the activity occurred at least three times.
-Code 1, supervision: if oversight,

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encouragement, or cueing was provided three or more times during the last 7 days.
-Code 2, limited assistance: if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on three or more times during the last 7 days.
-Code 3, extensive assistance: if resident performed part of the activity over the last 7 days and help of the following type(s) was provided three or more times:
- Weight-bearing support provided three or more times, OR
- Full staff performance of activity three or more times during part but not all of the last 7 days...
Coding Instructions for G0110, Column 2, ADL Support
Code for the most support provided over all shifts. Code regardless of how Column 1 ADL Self-Performance is coded.
-Code 0, no setup or physical help from staff: if resident completed activity with no help or oversight.
-Code 1, setup help only: if resident is provided with materials or devices necessary to perform the ADL independently. This can include giving or holding out an item that the resident takes from the caregiver.
-Code 2, one person physical assist: if the resident was assisted by one staff person.
-Code 3, two+ person physical assist: if the resident was assisted by two or more staff persons..."

No further information was presented prior to exit.

(1) "Dementia is not a specific disease. It is a descriptive term for a collection of symptoms that can be caused by a number of disorders that

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F 278	Continued From page 16 affect the brain. People with dementia have significantly impaired intellectual functioning that interferes with normal activities and relationships..." This information was obtained from the website: https://www.ninds.nih.gov/Disorders/All-Disorders/Dementia-Information-Page	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--	F 280	**F 280 – Right to Participate Planning Care- Revise CP** It is the practice of the facility to provide residents the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to receive the services and/or items included in the plan of care. (iv) The right to see the care plan, including the right to sign after significant changes to the plan of care.	

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(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

CRITERIA ONE:
Resident #4's care plan was reviewed and revised.

CRITERIA TWO:
Any and all residents have the potential to be affected by this alleged deficient practice.

CRITERIA THREE:
The interdisciplinary team will be re-educated on updating care plans to reflect resident's current status.

CRITERIA FOUR:
DON or designee will audit five care plans via our Eagle Room process for timely care plan updates to reflect resident's current conditions daily for five days, weekly for three weeks and then monthly for two months.
Results of the audit will be forwarded to the Quality Assurance and Performance Improvement Committee by the DON or designee for further review and follow up recommendations.

CRITERIA FIVE:
The facility's alleged date of compliance is 5/5/2017.

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(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
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 review and revise the comprehensive care plan for one of 26 residents in the survey sample, Resident #4.

The facility staff failed to update Resident #4's care plan following a physician order to float heels and float left hand above chest.

The findings include:

Resident #4 was admitted to the facility on 4/13/16 with a readmission date of 3/10/17 with diagnoses that included, but were not limited to, anemia (a low red blood cell count), obstructive uropathy [1] (a condition where urine cannot drain into the bladder from the kidneys), dementia and failure to thrive.

Resident #4's most recent MDS was a quarterly assessment with an ARD of 1/21/17. Resident #4 was coded on her BIMS (brief interview of mental status) as having a scored two out of a possible score of 15, indicating that Resident #4 was severely cognitively impaired with daily decision making.

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A review of Resident #4's clinical record revealed, in part, the following physician orders; "3/11/17. Float heels while patient is in bed, every shift. Float left hand above chest level to decrease swollen (sic), every shift."

A review of Resident #4's TAR (treatment administration record) revealed documentation, beginning on night shift 3/11/17, that the order was completed on each shift.

A review of Resident #4's comprehensive care plan dated 4/20/16 did not reveal any documentation related to floating heels or left hand.

On 3/22/17 at 1:19 p.m. an interview was conducted with LPN (licensed practical nurse) #2, a floor nurse. LPN #2 was asked who was responsible for updating care plans. LPN #2 stated that nursing was responsible. LPN #2 was asked under what circumstances a care plan would be updated. LPN #2 stated, "If the resident had a fall or needed antibiotics. Also if a catheter was ordered." LPN #2 was asked if the care plan would be revised if a resident was ordered to have heels floated. LPN #2 stated that it would. LPN #2 was given Resident #4's care plan to review. LPN #2 was asked whether or not there were revisions to Resident #4's care plan to reflect the new orders for floating the heels and left hand. LPN #2 stated, "It's not there, I don't know why. The care plan was not updated."

On 3/22/17 at 2:25 p.m. an interview was conducted with RN (registered nurse) #5, a floor nurse. RN #5 was asked when an order was received from a doctor directing care of a resident, should the care plan be revised to

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reflect the new order. RN #5 stated that it should. RN #5 was asked who would revise the care plan following the order. RN #5 stated that the nurse who took the order should revise the care plan. RN #5 was asked whether or not Resident #4's care plan had been revised to reflect the order to float heels and left hand. RN #5 reviewed Resident #4's care plan and stated that it had not.

An end of day meeting was conducted on 3/22/17 at 5:20 p.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and RN #1, the assistant director of nursing. The administrative staff was made aware of the above findings. A policy was requested regarding updating a care plan.

A review of the facility document titled "Requirements and Guidelines for Clinical Record Content" revealed, in part, the following documentation; "Care Plans. The care plan is completed and maintained in the EHR (electronic health record). The comprehensive care plan is prepared with input from an interdisciplinary team that includes the attending physician, nursing staff with responsibility for the patient, other appropriate disciplines as determined by the patient's needs and, to the extent practicable, the participation of the patient, legal representative or family member with patient's approval."

No further information was provided prior to the end of the survey process.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team

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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 280	Continued From page 21 members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1) (1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of care for one of 26 residents in the survey sample, Resident #5. The facility staff failed to clarify Resident #5's physician's order for Miralax (1) 17 mg (milligrams) daily; the medication is only dosed in grams. The findings include:	F 281	**F 281 – Services Provided Meet Professional Standards** It is the practice of the facility that the services provided or arranged by the facility, as outlined by the comprehensive care plan, must - (i) meet professional standards of quality. **CRITERIA ONE:** The Miralax order for Resident #5 was clarified and updated. **CRITERIA TWO:** Any and all residents have the potential to be affected by the alleged deficient practice.	

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Resident #5 was admitted to the facility on 2/8/16. Resident #5's diagnoses included but were not limited to: fibromyalgia (2), high blood pressure and dementia (3). Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/17/17, coded the resident's cognition as severely impaired.

Review of Resident #5's clinical record revealed a physician's order dated 2/24/17 that documented, "Start Miralax 17 mg daily..." Resident #5's February 2017 and March 2017 MARs (medication administration records) documented, "Miralax Powder- (Polyethylene Glycol 3350) Give 17 mg by mouth one time a day for Bowel regimant (sic)..."

Observation of Resident #5's bottle of Miralax powder revealed the medication pharmacy label that documented, "POLYETHYLENE GLYCOL 17G (grams)/DOSE POWDER GM (gram) - GIVE 17 MG BY MOUTH ONE TIME A DAY MIXED IN LIQUID OF CHOICE."

Resident #5's comprehensive care plan initiated on 2/8/16 failed to document information regarding Miralax administration.

On 3/22/17 at 11:10 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked to look up Miralax dosing instructions in the facility drug book. RN #2 looked through the drug book and stated she couldn't find Miralax but she had Miralax in the medication cart. RN #2 retrieved a bottle of another resident's Miralax and stated most residents were prescribed 17 grams. RN #2 stated the nurses measure 17 grams (of the powder) to the line on the inside of

CRITERIA THREE:
Licensed nurses will be re-educated on accurate clarification of MD orders.

CRITERIA FOUR:
DON or designee will audit five orders daily for five days, weekly for three weeks and then monthly for two months for accuracy.
Results of the audit will be forwarded to the Quality Assurance and Performance Improvement Committee by the DON or designee for further review and follow up recommendations.

CRITERIA FIVE:
The facility's alleged date of compliance is 5/5/2017.

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the Miralax bottle cap. RN #2 was asked why Resident #5's physician's order for Miralax documented to give 17 milligrams daily. RN #2 stated she didn't know. RN #2 was asked to provide any further information available. RN #2 stated she would research the matter and walked downstairs. At 11:25 a.m., RN #2 returned to the unit and stated she had called the pharmacy. RN #2 stated the Miralax was sent to the facility in a bottle with a cap that measured 17 grams but the physician's order documented to give 17 milligrams. At this time, LPN (licensed practical nurse) #1 (who was standing at the medication cart near RN #2) joined the interview. LPN #1 stated the normal dose of Miralax was 17 grams. LPN #1 stated Resident #5's physician's order was incorrectly typed and the nurses did not catch the error. LPN #1 stated one of the physician's interns had written the order and the nurses needed to call and clarify the order. LPN #1 stated nurses could not give 17 milligrams because that was a "little puff." LPN #1 stated the order would be corrected as soon as RN #2 called the physician.

On 3/22/17 at approximately 12:00 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing) and RN #1 (the assistant director of nursing). ASM #2 and RN #1 were asked what should be done if an unfamiliar dose of medication is prescribed by the physician. ASM #2 stated it depended on how familiar the nurse was with the medication. ASM #2 stated if the nurse was not familiar with the medication then the nurse should defer to the physician. ASM #2 stated if the medication was a medication that was used all the time then the nurse should call the physician to clarify the order. ASM #2 stated the pharmacy should

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"catch" the inaccurately prescribed dose, call the nurse then the nurse should call the physician for clarification. ASM #2 was asked what standard of practice the facility staff utilized. ASM #2 stated the staff utilizes the facility policies.

On 3/22/17 at 1:51 p.m., an interview was conducted with OSM (other staff member) #1 (the pharmacy consultant). OSM #1 stated Miralax can be administered at a minimum dose of 17 grams a day up to a dose of 34 grams a day. OSM #1 stated it was not possible to administer a dose of 17 milligrams of Miralax. OSM #1 was asked the pharmacy process for ensuring physician's orders were clarified and medication labels contained accurate documentation regarding dosing instructions. OSM #1 stated the pharmacy staff puts whatever direction is given from the physician's order into the pharmacy system. OSM #1 stated the dispensing pharmacist is supposed to verify the physician's order. When asked what should be done if the pharmacy receives an order to give 17 milligrams of Miralax, OSM #1 stated she would probably call the facility and get clarification.

On 3/22/17 at 2:06 p.m., RN #2 was asked if Resident #5's Miralax order was clarified. RN #2 stated the physician wanted Resident #5 to receive 17 grams of Miralax. RN #2 stated the Miralax was measured in grams and there was no way to give milligrams.

On 3/22/17 at 2:11 p.m., an interview was conducted with RN #4 (a nurse who had administered Miralax to Resident #5). RN #4 stated she had been administering 17 grams of Miralax to the resident.

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On 3/22/17 at 5:40 p.m., ASM #1 (the administrator), ASM #2, ASM #3 (the quality assurance consultant) and RN #1 were made aware of the above findings.

The facility policy titled, "MEDICATION ADMINISTRATION: ORAL" failed to document information regarding clarification of physician's orders.

The facility pharmacy policy titled, "4.1 Physician/Prescriber Authorization and Communication of Orders to Pharmacy" documented, "10. Pharmacy may contact Facility staff via fax or telephone before dispensing a medication when the pharmacist believes that there is a need to clarify the medication order because the order is unclear, incomplete or vague, contraindicated, or has a severe drug-drug interaction. 10.1 Facility staff should regularly check the fax machine(s) for any pharmacy communication. 10.2 Pharmacy will hold medication orders until Physician/Prescriber is able to clarify the order. 10.3 Facility should contact Physician/Prescriber when staff is notified by Pharmacy of an order requiring clarification. 10.4 Facility should explain the issue to the Physician/Prescriber, document the clarification and document any new orders received. 10.5 Facility staff should then communicate the result and any new orders or directions to the Pharmacy..."

No further information was presented prior to exit.

(1) Miralax is used to relieve constipation. "Active ingredient (in each dose) (Bottle Only) Polyethylene Glycol 3350, 17 g (grams) (cap filled to line)." This information was obtained from the

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F 281	Continued From page 26 website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d69ce3d4-7ca4-4fe3-b49e-6655e48d6963 (2) "Fibromyalgia is a disorder that causes muscle pain and fatigue..." This information was obtained from the website: https://medlineplus.gov/fibromyalgia.html (3) "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..." 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=dementia&_ga=1.98220255.139120270.1477942321	F 281		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 371	**F 371 Food Procure, Store/Prepare/ Serve - Sanitary** It is the practice of the facility to (i)(1) – Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulation. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling-practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption.	

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from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review it was determined that facility staff failed to prepare and serve food in a safe and sanitary manner.

The facility staff failed to ensure the kitchen mixer was clean and free from debris.

The findings include:

On 3/21/17 at 11:45 a.m., observation of the kitchen was conducted. The mixer was observed with debris that appeared to be cake batter, on the underside of the head of the mixer. At 11:50 a.m., an interview was conducted with OSM (other staff member) # 2, the Dietary Manager. When asked if the mixer was clean and ready for use, she stated, "Let me see." OSM #2 looked at the mixer. When asked if she could identify if the mixer was clean, OSM # 2 stated there was debris on the mixer. When asked how often the mixer was cleaned, OSM #2 stated, "After every use." When asked when the mixer was last used, OSM #2 asked her dietary staff. OSM #2 stated, "The mixer was used last night (Monday) to make cake. No one used it over the weekend."

CRITERIA ONE:
At the time of notification, the kitchen mixer was cleaned.

CRITERIA TWO:
Any and all residents have a potential to be affected by this alleged deficient practice.

CRITERIA THREE:
The Dietary Manager and Dietary Staff were educated on the cleaning procedure for the mixer.

CRITERIA FOUR:
The Administrator or designee will audit the cleanliness of the mixer in the kitchen daily for five days, weekly for three weeks and then monthly for two months for cleanliness.
Results of the audit will be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator or designee for further review and follow up recommendations.

CRITERIA FIVE:
The facility's alleged date of compliance is 5/5/2017.

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When asked if the mixer should have been cleaned after use on Monday night, OSM #2 stated. "Yes."

On 3/21/17 at approximately 12:30 p.m., OSM #2 provided the facility menu that showed carrot cake was made in place of spice cake on 3/20/17 evening shift.

On 3/22/17 at 5:24 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse were made aware of the above concerns.

The facility policy titled, "Cleaning Procedure-Mixer" documented the following: "Guidelines. 1. Immediately after use, take attachments, bowl and removable parts to ware washing sink. Wash in hot water, rinse and sanitize. 2. Unplug the mixer. Check electric cord for damage. 3. Fill bucket with detergent solution. 4. Scrub all stationary parts of mixer suing detergent solution. Give special attention to" Underside if head, corners, cord, handles, underneath, rolled rims, switches, and walls around area. 5. Rinse with cloth frequently ensuring all parts are sanitized. 6. Air dry. 7. Replace removable parts. Cover with an approved plastic bag or manufacturer's equipment cover. 8 Wash and return all cleaning equipment to proper storage area."

No further information was presented prior to exit.

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F 371	Continued From page 29	F 371	**F 372 – Dispose Garbage & Refuse Properly**	
F 372 SS=F	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY	F 372	It is the practice of the facility to dispose of garbage and refuse properly.	

(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, it was determined that facility staff failed to dispose of garbage in a sanitary manner.

The facility staff failed to ensure the two facility dumpsters were free from debris around the area.

The findings include:

On 3/21/17 at 12:00 p.m., observation of the dumpster area was conducted with OSM (other staff member) #2, the dietary manager. Three pairs of used gloves were observed behind the dumpster and three bags of tied up trash were observed near the woods behind the dumpster. OSM #2 confirmed that she also observed these items. On 3/21/17 at 12:02 p.m. an interview was conducted with OSM #2. When asked who was responsible for ensuring the dumpsters were clean and free of debris around the area, OSM #2 stated that she was not sure. OSM #2 stated, "I think it is us and housekeeping." When asked when dumpsters were checked for debris, OSM #2 stated, "Well I think Dietary was just making sure the trash they threw out was actually going in the dumpster. I'll go get gloves and pick this stuff up." OSM #2 then asked the maintenance director (OSM #7) who was outside the building who was responsible for picking up trash around the dumpster. OSM #7 stated, "That would be

CRITERIA ONE:
At the time of notification, the trash around the dumpster was disposed of properly.

CRITERIA TWO:
Any and all residents have the potential to be affected by this alleged deficient practice.

CRITERIA THREE:
The Housekeeping Department and Dietary Department will be educated on the proper procedure for the disposing of garbage and refuse.

CRITERIA FOUR:
The Administrator or designee will audit the disposal of garbage and refuse for handling for five days, weekly for three weeks and then monthly for two months. Results of the audit will be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator or designee for further review and follow up recommendations.

CRITERIA FIVE:
The facility's alleged date of compliance is 5/5/2017.

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you and housekeeping." OSM #2 stated, "Now I know. I will be checking."

On 3/22/17 at approximately 5:00 p.m. OSM #2, provided this writer evidence that she had in-serviced her dietary staff about keeping the dumpsters area clean.

On 3/22/17 at 5:24 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse were made aware of the above findings. When asked who was responsible for ensuring the dumpsters were free from debris, ASM #1 stated, "Housekeeping."

On 3/23/17 at 8:05 a.m., an interview was conducted with OSM #5, the Director of Housekeeping. OSM #5 stated it was housekeeping and dietary's responsibility to ensure dumpsters were free from debris. OSM #5 stated every time staff is throwing items away, they should be checking.

Facility policy titled, "Waste removal" did not address dumpsters being free from debris.

No further information was presented prior to exit.

F 372

F 386 SS=D 483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS

(b) Physician Visits
The physician must--

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;

F 386 – Physician Visits – Review Care/ Notes/Orders

F 386 It is the practice of the facility to ensure physician visits. The physician must (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contradictions.

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(2) Write, sign, and date progress notes at each visit; and

(3) Sign and date all orders with the exception of influenza and pneumococcal 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 timely physician visits for one of 26 residents in the survey sample, Resident #3.

The facility staff failed to ensure Resident #3's physician wrote a progress note from 1/4/17 to 3/19/17, a total of 74 days.

The findings include;

Resident #3 was admitted to the facility on 8/5/2008 with a readmission date of 1/8/2016, with diagnoses that included, but were not limited to, heart failure, high blood pressure, diabetes and dementia.

Resident #3's most recent MDS (minimum data set) is a quarterly assessment with an ARD (assessment reference date) of 1/23/17. Resident #3 was coded as having a BIMS (brief interview of mental status) score of four out of a possible 15, indicating that Resident #3 is severely cognitively impaired with daily decision making.

A review of Resident #3's clinical record revealed progress notes that were dated 1/4/17 and 3/19/17, a total of 74 days between notes. No

CRITERIA ONE:
At the time of notification, Resident #3's physician visits were up to date.

CRITERIA TWO:
Any and all residents have a potential to be affected by this alleged deficient practice.

CRITERIA THREE:
The Medical Records Clerk and Physician involved will be re-educated on timely physician visits.

CRITERIA FOUR:
Administrator or designee will audit five physician visits daily for five days, weekly for three weeks and then monthly for two months.
Results of the audit will be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator or designee for further review and follow up recommendations.

CRITERIA FIVE:
The facility's alleged date of compliance is 5/5/2017.

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other physician notes were provided.

On 3/22/17 at 1:00 p.m. ASM (administrative staff member) #2, the director of nursing, stated that she did not have any evidence of the physician seeing Resident #3 between 1/4/17 and 3/19/17. ASM #2 further stated, "We did realize that he (Resident #3) had not been seen when we audited the records and we sent a letter to the physician. This doctor is in the building every day. I am sure that he would have talked to the resident (Resident #3) and/or his family. We recognized that he (Resident #3) hadn't been seen and we sent a certified letter to the MD (medical doctor) and he came in to see him four days later. He was only four days late because we have a 10 day grace period." ASM #2 verified that Resident #3 was not seen by a physician for a period of 74 days.

Review of the facility document titled, "Requirements and Guidelines for Clinical Record Content" revealed, in part the following documentation; "Physician Visits and Progress Notes. At a minimum, 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. 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 rules."

An end of day meeting was conducted on 3/22/17 at 5:20 p.m. with ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the quality assurance consultant and RN (registered nurse) #1, the assistant director of nursing. The administrative staff was made aware of the above findings.

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F 386	Continued From page 33 No further information was provided prior to the end of the survey process.	F 386	**F 425 – Pharmaceutical SVC – Accurate Procedures, RPH**	
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide pharmaceutical services for one of 26 residents in the survey sample, Resident #5. The pharmacy failed to clarify Resident #5's physician's order for Miralax 17 mg (milligrams) daily. The pharmacy dispensed a bottle of Miralax to the facility with a label that documented directions to give 17 mg daily although the medication is only dosed in grams. The findings include: Resident #5 was admitted to the facility on 2/8/16. Resident #5's diagnoses included but were not limited to: fibromyalgia (2), high blood pressure	F 425	It is the practice of the facility to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility. **CRITERIA ONE:** The Miralax order for Resident #5 was clarified and updated. **CRITERIA TWO:** Any and all residents have the potential to be affected by the alleged deficient practice. **CRITERIA THREE:** The Pharmacist Consultant and licensed nurses will be re-educated on clarification of MD orders. **CRITERIA FOUR:** DON or designee will audit five orders daily for five days, weekly for three weeks and then monthly for two months for accuracy. Results of the audit will be forwarded to the Quality Assurance and Performance	

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and dementia (3). Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/17/17, coded the resident's cognition as severely impaired.

Review of Resident #5's clinical record revealed a physician's order dated 2/24/17 that documented, "Start Miralax 17 mg daily..." Resident #5's February 2017 and March 2017 MARs (medication administration records) documented, "Miralax Powder- (Polyethylene Glycol 3350) Give 17 mg by mouth one time a day for Bowel regimant (sic)..."

Observation of Resident #5's bottle of Miralax powder revealed the medication pharmacy label that documented, "POLYETHYLENE GLYCOL 17G (grams)/DOSE POWDER GM (gram) - GIVE 17 MG BY MOUTH ONE TIME A DAY MIXED IN LIQUID OF CHOICE."

Resident #5's comprehensive care plan initiated on 2/8/16 failed to document information regarding Miralax administration.

On 3/22/17 at 11:10 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked to look up Miralax dosing instructions in the facility drug book. RN #2 looked through the drug book and stated she couldn't find Miralax but she had Miralax in the medication cart. RN #2 retrieved a bottle of another resident's Miralax and stated most residents were prescribed 17 grams. RN #2 stated the nurses measure 17 grams (of the powder) to the line on the inside of the Miralax bottle cap. RN #2 was asked why Resident #5's physician's order for Miralax documented to give 17 milligrams daily. RN #2

Improvement Committee by the DON or designee for further review and follow up recommendations.

CRITERIA FIVE:
The facility's alleged date of compliance is 5/5/2017.

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stated she didn't know. RN #2 was asked to provide any further information available. RN #2 agreed to research the matter and walked downstairs. At 11:25 a.m., RN #2 returned to the unit and stated she had called the pharmacy. RN #2 stated the Miralax was sent to the facility in a bottle with a cap that measured 17 grams but the physician's order documented to give 17 milligrams. At this time, LPN (licensed practical nurse) #1 (who was standing at the medication cart near RN #2) joined the interview. LPN #1 stated the normal dose of Miralax was 17 grams. LPN #1 stated Resident #5's physician's order was incorrectly typed and the nurses did not catch the error. LPN #1 stated one of the physician's interns had written the order and the nurses needed to call and clarify the order. LPN #1 stated nurses could not give 17 milligrams because that was a "little puff." LPN #1 stated the order would be corrected as soon as RN #2 called the physician.

On 3/22/17 at approximately 12:00 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing) and RN #1 (the assistant director of nursing). ASM #2 and RN #1 were asked what should be done if an unfamiliar dose of medication is prescribed by the physician. ASM #2 stated it depended on how familiar the nurse was with the medication. ASM #2 stated if the nurse was not familiar with the medication then the nurse should defer to the physician. ASM #2 stated if the medication was a medication that was used all the time then the nurse should call the physician to clarify the order. ASM #2 stated the pharmacy should "catch" the inaccurately prescribed dose, call the nurse then the nurse should call the physician for clarification. ASM #2 was asked what standard of

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practice the facility staff utilized. ASM #2 stated the staff utilizes the facility policies.

On 3/22/17 at 1:51 p.m., an interview was conducted with OSM (other staff member) #1 (the pharmacy consultant). OSM #1 stated Miralax can be administered at a minimum dose of 17 grams a day up to a dose of 34 grams a day. OSM #1 stated it was not possible to administer a dose of 17 milligrams of Miralax. OSM #1 was asked the pharmacy process for ensuring physician's orders were clarified and medication labels contained accurate documentation regarding dosing instructions. OSM #1 stated the pharmacy staff puts whatever direction is given from the physician's order into the pharmacy system. OSM #1 stated the dispensing pharmacist is supposed to verify the physician's order. When asked what should be done if the pharmacy receives an order to give 17 milligrams of Miralax, OSM #1 stated she would probably call the facility and get clarification.

On 3/22/17 at 2:06 p.m., RN #2 was asked if Resident #5's Miralax order was clarified. RN #2 stated the physician wanted Resident #5 to receive 17 grams of Miralax. RN #2 stated the Miralax was measured in grams and there was no way to give milligrams.

On 3/22/17 at 2:11 p.m., an interview was conducted with RN #4 (a nurse who had administered Miralax to Resident #5). RN #4 stated she had been administering 17 grams of Miralax to the resident.

On 3/22/17 at 5:40 p.m., ASM #1 (the administrator), ASM #2, ASM #3 (the quality assurance consultant) and RN #1 were made

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aware of the above findings.

The facility policy titled, "MEDICATION ADMINISTRATION: ORAL" failed to document information regarding clarification of physician's orders.

The facility pharmacy policy titled, "4.1 Physician/Prescriber Authorization and Communication of Orders to Pharmacy" documented, "10. Pharmacy may contact Facility staff via fax or telephone before dispensing a medication when the pharmacist believes that there is a need to clarify the medication order because the order is unclear, incomplete or vague, contraindicated, or has a severe drug-drug interaction. 10.1 Facility staff should regularly check the fax machine(s) for any pharmacy communication. 10.2 Pharmacy will hold medication orders until Physician/Prescriber is able to clarify the order. 10.3 Facility should contact Physician/Prescriber when staff is notified by Pharmacy of an order requiring clarification. 10.4 Facility should explain the issue to the Physician/Prescriber, document the clarification and document any new orders received. 10.5 Facility staff should then communicate the result and any new orders or directions to the Pharmacy..."

No further information was presented prior to exit.

(1) Miralax is used to relieve constipation. "Active ingredient (in each dose) (Bottle Only) Polyethylene Glycol 3350, 17 g (grams) (cap filled to line)." This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d69ce3d4-7ca4-4fe3-b49e-6655e48d69

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(2) "Fibromyalgia is a disorder that causes muscle pain and fatigue..." This information was obtained from the website: https://medlineplus.gov/fibromyalgia.html

(3) "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..." 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=dementia&_ga=1.98220255.139120270.1477942321

F 507 SS=D — 483.50(a)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS

(a) Laboratory Services

(2) The facility must-

(iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review it was determined, that facility staff failed to ensure laboratory results were filed in one resident record (Resident #14) out of 26 residents in the survey sample.

The facility staff failed to file the 3/13/17 TSH (thyroid stimulating hormone (1)) and Vitamin D

F 507

F 507 – Lab Reports in Record – Lab Name/Address

It is the practice of the facility to file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.

CRITERIA ONE:
Upon notification, the laboratory results were filed in Resident #14's record.

CRITERIA TWO:
Any and all residents have a potential to be affected by this alleged deficient practice.

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laboratory results in Resident #14's record.

The findings include:

Resident #14 was admitted to the facility on 3/9/17 with diagnoses that included but were not limited to: bleeding in the brain, depression, weakness, falls, high blood pressure and arthritis.

The most recent MDS (minimum data set), a five day review, with an ARD (assessment reference date) of 3/16/17 coded the resident as having scored a 7 out of 15 on the brief interview for mental status indicating the resident was severely impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform after the meal tray was set up.

Review of the physician's orders dated 3/11/17 documented, "CBC w/diff (with differential) [2], Chem (Chemistry) 24 (3), TSH and Vit (vitamin) D."

Review of the March 2017 medication administration record documented, "CBC w/diff, chem (chemistry) 24, TSH and Vit D." There was a check mark and a nurse's initials in the box dated 3/13/17 indicating the laboratory specimens were obtained.

Review of the 3/13/17 laboratory tracking log documented, "(Name of resident T#14) 3/13/17 CBC W/DIFFERENTIAL, TSH, VITAMIN D...MISCELLANEOUS TEST (the chemistry 24). The phlebotomist had initialed that the laboratory specimens had been obtained. Review of Resident #14's clinical record documented, "TSH

CRITERIA THREE:
Licensed nurses will be re-educated on promptly obtaining lab results and processing them using facility lab tracking guideline.

CRITERIA FOUR:
DON or designee will audit five laboratory results daily for five days, weekly for three weeks and then monthly for two months for timeliness of filing.
Results of the audit will be forwarded to the Quality Assurance and Performance Improvement Committee by the DON or designee for further review and follow up recommendations.

CRITERIA FIVE:
The facility's alleged date of compliance is 5/5/2017.

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PENDING; Vitamin D PENDING. Further review of the clinical record did not evidence documentation of the TSH and Vitamin D laboratory results.

An interview was conducted on 3/22/17 at 9:10 a.m. RN (registered nurse) #10, the unit manager. When asked how long it took to receive pending laboratory test results, RN #10 stated, "Usually from the time it's pending to get it is between 3:00 p.m. and 4 p.m. (that day)."

An interview was conducted on 3/22/17 at 10:40 a.m. with RN #1, the assistant director of nursing. When asked about the process staff follows to obtain pending laboratory specimens, RN #1 stated, "We go into the lab (laboratory) website and print it out. We need to do our due diligence." When asked who was responsible for following up, RN #1 stated, "The nurse is to follow up on it." When asked why it was necessary to have the laboratory results on the chart, RN #1 stated, "Because as a nurse you have an order and they are being tracked." RN #1 was made aware of the findings at that time.

An interview was conducted on 3/22/17 at 1:45 p.m. with RN #11. When asked about the process staff follows when obtaining pending laboratory results, RN #11 stated, "First thing we check the lab website and print them out." RN #11 stated, "If it's pending we pass it on to the next shift and keep on passing it on until we get the results." When asked how staff knew that they were waiting for laboratory results, RN #11 stated, "We document it in (name of software)."

Review of the 3/13/17 at 7:47 p.m. nurses notes documented, "TSH and vitamin D level results

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pending." Review of the nurse's notes from 3/14/17 through 3/17/17 did not evidence documentation regarding the pending laboratory results.

On 3/22/17 at 5:15 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the quality consultant and RN #1, the assistant director of nursing were made aware of the findings.

Review of the facility's policy titled, "LABORATORY TRACKING GUIDELINES" documented, "PURPOSE: To establish guidelines to track the completion, reporting and monitoring of laboratory (lab) tests and results. GUIDELINES: Lab test results received from an external lab: incorporated into the patient's clinical record, either paper or electronic form.

No further information was provided prior to exit.

TSH -- A health care provider usually performs the TSH blood test first to check how well the thyroid is working. The TSH test measures the amount of TSH a person's pituitary is secreting. The TSH test is the most accurate test for diagnosing both hyperthyroidism and hypothyroidism. Generally, a below-normal level of TSH suggests hyperthyroidism. An abnormally high TSH level suggests hypothyroidism. This information was obtained from: https://www.niddk.nih.gov/health-information/diagnostic-tests/thyroid

CBC with differential -- A blood test that measures the following components in a sample of blood: red blood cells, white blood cells, platelets, and hemoglobin. A complete blood

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F 507	Continued From page 42 count (CBC) with differential also measures the levels of the five types of white blood cells found in blood: neutrophils, lymphocytes, monocytes, eosinophils, and basophils. The CBC is used to assess overall health and to diagnose and guide treatment of numerous diseases. This information was obtained from: https://aidsinfo.nih.gov/education-materials/glossary/163/complete-blood-count Chemistry 24 -- The basic metabolic panel (BMP) is a group of tests that measures different chemicals in the blood. These tests usually are done on the fluid (plasma) part of blood. The tests can give doctors information about your muscles (including the heart), bones, and organs, such as the kidneys and liver. This information was obtained from: https://www.nhlbi.nih.gov/health/health-topics/topics/bdt/types	F 507		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 514	**F 514 – Res Records – Complete/ Accurate/Accessible** It is the practice of the facility to maintain medical records on each resident that are – (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized. (5) The medical record must contain – (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under 483.50	

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(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain a complete and accurate clinical record for one of 26 residents in the survey sample, Resident #2.

Facility staff documented that a 20 Fr (French) Foley catheter was placed for Resident #2 on 12/31/16 when Resident #2 had an order for a 16 Fr Foley catheter.

The findings include:

Resident #2 was admitted to the facility on 4/11/14 with diagnoses that included but were not limited to bipolar disorder, repeated UTIs (urinary tract infections), falls, major depressive disorder with manic episodes, anorexia, anemia, and vitamin D deficiency. Resident #2's most recent

CRITERIA ONE:
At the time of notification from surveyor, Resident #2's Foley Catheter has been discontinued.

CRITERIA TWO:
Any resident with a Foley Catheter has the potential to be affected by this alleged deficient practice.

CRITERIA THREE:
Licensed nurses will be re-educated on a complete individualized clinical record keeping and accurately documenting resident's information.

CRITERIA FOUR:
DON or designee will audit five resident charts daily for five days, weekly for three weeks and then monthly for two months. Results of the audit will be forwarded to the Quality Assurance and Performance Improvement Committee by the DON or designee for further review and follow up recommendations.

CRITERIA FIVE:
The facility's alleged date of compliance is 5/5/2017.

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 03/23/2017

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 514	Continued From page 44	F 514		

MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/20/17. Resident #2 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #2 was coded as requiring extensive assistance from staff with transfers, dressing, and personal hygiene; and total dependence on staff with locomotion and bathing. Resident #2 was coded as needing limited assistance with one staff member with eating.

Review of Resident #2's physician orders revealed an order dated 11/11/2016 that documented the following: "Maintain indwelling foley catheter with 16 F 10 cc to facilitate wound healing. change prn (as needed) for obstruction." This order was discontinued on 3/19/17.

Review of Resident #2's nursing notes dated 12/31/16, documented the following: "Resident alert and verbally responsive. Assisted with incontinent care and ADLS (activities of daily living) as needed. Poor appetite noted for meals. Resident encouraged to eat and drink fluids. Resident received scheduled eye drops as per order. Foley catheter noted leaking. Foley removed and inserted new foley catheter 20Fr, no discomfort noted. Foley catheter noted with 50cc clear yellow urine. Resident denies pain, no distress or discomfort noted. No SOB (shortness of breath) noted. Resident currently lying in bed with call light within reach, bed in low position. V/S (vital signs) B/P (blood pressure) 112/66, P (pulse) 78, Temp (temperature) 97.4, 02 (oxygen) sat (saturation) 97 % (percent) RA (Room Air). Will continue to monitor."

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F 514	Continued From page 45	F 514		

On 3/22/17 at 1:17 p.m., an interview was conducted with LPN (licensed practical nurse) #2, the nurse who wrote the above note regarding residents with foley catheters. OSM #2 stated, "You look at the orders and insert the foley as needed." LPN #2 stated that it was never okay to replace a foley with the wrong size. LPN #2 reviewed looked at her note and the physician's order for the 16 Fr foley and stated, "I don't remember this that well but I do recall looking at the orders. I think I made a mistake with typing."

On 3/23/17, at 5:24 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the QA (quality assurance consultant) were made aware of the above concerns.

Facility Policy titled, "Clinical Record System" documents in part the following: "Documentation in the clinical record is expected to be timely, and to accurately reflect each patient's condition. Any individual who provides care to the patient may document care in the record. Each entry in the record is signed or initialed as appropriate, dated and timed for the day written and contains the title of the person making the entry."

No further information was presented prior to exit.

VDH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0153	A. BUILDING _____ B. WING _____	03/23/2017

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

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 3/21/17 through 3/23/17. Complaints were investigated during the survey. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 150 certified bed facility was 132 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #1 through #21) and five closed record reviews (Residents #22 through #26).	F 000	**12VAC5-371-140 E 3b – Policies and Procedures** It is the practice of the facility to ensure a criminal background check is obtained in accordance with the laws of the State of Virginia. **CRITERIA ONE:** At the time of the survey, C.N.A. #5 had a background check in their file but it was not done timely. At the time of notification by the state survey team, the facility conducted a background check on C.N.A. #6. **CRITERIA TWO:** Any staff member had the potential to be affected by this alleged deficient practice. **CRITERIA THREE:** The Human Resources Director will be educated on conducting criminal background checks within the guidelines of specific state and federal laws. **CRITERIA FOUR:** Administrator or designee will audit five employee files daily for five days, weekly for three weeks and then monthly for two months. Results of the audit will be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator or designee for further review and follow up recommendations. **CRITERIA FIVE:** The facility's alleged date of compliance is 5/5/2017.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12VAC5-371-270 B -- Social Services-cross reference to F 251 12VAC5-371-370 -- Maintenance and Housekeeping -- cross reference to F 252 12VAC5-371-250 A -- Resident Assessment & Care Planning - cross referenced to F 278 12VAC5-371- 250 F -- Resident Assessment & Care Planning - cross referenced to F 280 12VAC5-371- B 1 -- Director of Nurses - cross referenced to F 281	F 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/17/17

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F 001	Continued From Page 1 12VAC5-371- 340 D 3 -- Dietary & Food Service Program - cross referenced to F 371 12VAC5-371- 240 E -- Physician Services - cross referenced to F 386 12VAC5-371- 300 A - Pharmaceutical Services - cross referenced to F 425 12VAC5-371- 360 E 10 -- Clinical Records-cross referenced to F 507 12 VAC 5 - 371 - 360 E -- Clinical Records -- cross referenced to F 514 12VAC5-371-140 E 3b -- Policies and procedures - SEE CITATION BELOW: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure a criminal background check was obtained in accordance with the laws of the State of Virginia, for two of 25 employee records reviewed. The findings include: Review of the state regulation 12VAC5-371-140 documents "E. Personnel policies and procedures shall include, but are not limited to: 3. An accurate and complete personnel record for each employee including...b. a criminal record check;" On 3/22/17 a review of 25 employee records of new hires for the last two years was conducted. This review revealed the following: CNA (certified nurse's assistant) # 5 was hired on 5/13/15. The facility staff failed to obtain a criminal background check until 3/22/17. There was no documentation in CNA # 5's employee file	F 001		

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F 001	Continued From Page 2 that a criminal background check had been requested. CNA # 6 was hired on 3/25/15. The facility staff failed to obtain a criminal background check until 5/20/15 (56 days after hire). During an interview on 3/22/17 at 1:30 p.m. with OSM (other staff member) # 9, the Human Resources staff member, OSM # 9 stated that she (OSM # 9) could not find a criminal check for (name of CNA # 5). OSM # 9 further stated that (name of CNA # 5) was a transfer from another location so she (OSM # 9) called to see if the criminal check could be found in their (the other location's) files. The criminal check could not be located. OSM # 9 stated that for CNA # 6 that the check done on 5/20/15 was the only one that she could find. During an interview on 3/22/17 at approximately 5:20 p.m. with ASM (administrative staff member) # 1, the administrator, this concern was reviewed. A review of the facility policy "1100.12 CRIMINAL HISTORY CHECK" revealed, in part, the following documentation: "It is the policy of (name of facility) to conduct criminal background checks within the guidelines of specific state and federal laws. All applicants who are offered employment will undergo a criminal background check. Job offers are made contingent upon successful completion of criminal background checks and other pre-employment checks and policies." No further information was provided prior to the end of the survey process.	F 001		