ManorCare Health Services- Richmond
2125 Hilliard Road
Richmond, Virginia 23228
804.266.9666
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ManorCare
Health Services

April 1, 2015

Ms. Wietske G. Weigel-Delano, LTC Supervisor
Office of Licensure and Certification
Division of Long Term Care Services
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, Virginia 23233

Dear Ms. Weigel-Delano:

Attached please find the Plan of Correction for HCR-ManorCare Richmond on the corrected copy of the form CMS 2567, related to the standard survey completed on March 4, 2015. As noted in the Plan of Correction, the facility's date of alleged compliance is April 18, 2015.

Please contact me if you have any further questions or concerns.

Thanks.

Sincerely,

Elizabeth Nugent

Elizabeth Nugent, LNHA
Administrator

# 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 31, 2015

Ms. Elizabeth Nugent, Administrator
Manorcare Health Services-Stratford Hall
2125 Hilliard Road
Richmond, VA 23228-4600

Dear Ms. Nugent:

RE: Manorcare Health Services-Stratford Hall
Provider Number 495045

Enclosed is a corrected copy of the form CMS 2567 for the standard survey ending March 4, 2015. A correction has been made to citation F280 based on statement, as we discussed. Please submit the Plan of Correction on the corrected survey report.

The letter, dated 3/18/2015, that accompanied the original survey report is still applicable. If you have any questions about this letter, please feel free to contact me at 804/367-2100. Thank you.

Sincerely,

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

Enclosure

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495045 | A. BUILDING ______<br>B. WING ______ | 03/04/2015 |

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| MANORCARE HEALTH SERVICES-STRATFORD HALL REVISED | 2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 03/3/15 through 03/4/15. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 194 certified bed facility was 156 at the time of the survey. The survey sample consisted of 23 current resident reviews (Residents #1 through 21, Residents #27 and #28) and five closed record reviews (Residents #22 through #26). | F 000 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies cited herein.<br><br>To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. | |
| F 160 SS=D | 483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH<br><br>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to convey resident funds within 30 days after death for one of 28 residents in the survey sample, Resident #22.<br><br>Resident # 22 expired at the facility on 12/18/14; the Resident's fund account was still open on 3/4/15 and had a balance 76 days after the Resident expired. | F 160 | **F160**<br><br>It is the intended practice of this facility that upon the death of a resident with a personal fund deposited with the facility, the facility will convey within 30 days the resident's funds and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.<br><br>**Criteria 1**<br>Resident #22's account was closed out. | 04/18/15 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Nugent, LNHA Elizabeth Nugent, LNHA
TITLE: Administrator
(X6) DATE: 4/1/15

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

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| F 160 | Continued From page 1<br>The findings include:<br><br>Resident # 22 was admitted to the facility on 3/20/09 and readmitted on 7/22/14 with diagnoses that included but were not limited to: coronary artery disease, diabetes, arthritis, Alzheimer's disease, anxiety, hyperlipidemia, schizophrenia, and depression.<br><br>The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 10/14/14, coded Resident # 22 as rarely understands others and as rarely able to make herself understood. Resident # 22 was also coded as being severely cognitively impaired for daily decision making. Resident # 22 expired at the facility on 12/18/14. There was no evidence in the clinical record for the conveyance of the resident funds.<br><br>During an interview on 3/4/15 at 1:40 p.m. with OSM (other staff member) # 3, the business office manager, it was revealed that Resident # 22 still had an open resident funds account with a balance of $1,191.61. OSM # 3 stated that she did not realize that (name of Resident # 22) had a resident fund account.<br><br>During an interview on 3/4/15 at 2:15 p.m. with ASM (administrative staff member) # 1, the administrator, this finding was reviewed. ASM # 1 stated that she had just given approval for the account to be closed. A request for the facility policy was made at this time.<br><br>On 3/4/15 at 2:40 p.m. ASM # 1 presented a fax to "NDC" (National Data Care) and stated that this is the first step that needed to be done to | F 160 | **Criteria 2**<br>All residents with personal funds deposited with the facility have the potential to be affected.<br><br>Audit completed on all residents with personal funds to ensure funds were conveyed within 30days of discharge.<br><br>**Criteria 3**<br>Business Office staff have been reeducated on resident personal fund accounts and proper procedures on how to close personal fund accounts.<br><br>**Criteria 4**<br>Administrator/designee will audit all residents with personal funds to ensure funds were conveyed within 30 days of discharge weekly x4 weeks and monthly x2 months and report to QAA recommendations.<br><br>**Criteria 5**<br>The facilities alleged date of compliance is April 18, 2015. | |

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| F 160 | Continued From page 2<br>begin the process of closing the account. The "Status Change Form" was the item that was faxed.<br><br>On 3/4/15 at 3:10 p.m. OSM # 3 reviewed a copy of what the facility uses to guide them in regards to resident fund accounts. Identifying the "Resident Fund Management System" as the online guide that is used; a copy of a portion of this guide was printed and presented. On page # 7 of this guide the following was documented: "Resident Expires: A Status Change form should be faxed to NDC immediately following the resident's death so that direct deposits received after the date of expiration will be returned to their source...The account will remain open until NDC receives the Status Change form instructing them to close the account. The account should be closed immediately unless waiting for Social Security to take back a payment."<br><br>No further information was provided prior to exit. | F 160 | | |
| F 226 SS=D | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, and employee record review, it was determined that the facility staff failed to implement abuse policies for one (CNA (certified | F 226 | F226<br><br>It is the intended practice of this facility to develop and implement written policies and procedures that prohibit mistreat, neglect, and abuse of residents and misappropriation of resident property.<br><br>Criteria 1<br>CNA #3's employee references were checked and placed into her employee file. | 04/18/15 |

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| F 226 | Continued From page 3<br>nursing assistant) #3) of five employee records reviewed.<br><br>The facility was unable to provide evidence that employee references were obtained per the facility abuse policy, for CNA (certified nursing assistant) #3, who was newly hired employees.<br><br>The findings include:<br><br>Five employee records of new hires for the last four months were requested and reviewed.<br><br>Review of CNA #3's employee record revealed that CNA #3 was hired as a CNA on 12/29/14. Further review of CNA #3's employee record failed to evidence that employee references were completed prior to the hire date.<br><br>During an interview on 3/4/15 at approximately 2:25 p.m. with OSM (other staff member) #6, Director of Human Resources, OSM #6 was asked whether or not employee reference checks were completed at the time of CNA #3's hire date. OSM #6 stated that she was unable to find in the record where that was done. OSM #6 was asked to describe the verification process for any new hires prior to the hire date. OSM #6 responded, "When we receive the employment application we set up for an interview, once a decision is made to hire the applicant we invite the applicant in for a pre-employment appointment. At that time we complete the sworn statement and we obtain consent to complete the background checks. The references are requested during this appointment and we usually check references by telephone and note our conversation on the | F 226 | **Criteria 2**<br>All employee files have the potential to be affected.<br><br>All current employee files were checked for reference checks on file.<br><br>**Criteria 3**<br>HR staff have been reeducated on checking references for all new hires prior to hire date and have been reeducated on facility abuse policies.<br><br>**Criteria 4**<br>Administrator/designee will audit all new hire employee files weekly x4 weeks and monthly x2 months and report to QAA recommendations.<br><br>**Criteria 5**<br>The facilities alleged date of compliance is April 18, 2015. | |

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| F 226 | Continued From page 4<br>consent form." OSM #6 was asked whether or not this was done for CNA #3, OSM #6 stated, "I am sure we did it, we just failed to document this in her record. I can't find it."<br><br>The facility's policy "Reference Requests for Prospective Employees" documented, "Policy Statement. It is (facility name) policy to obtain and evaluate references for all potential employees. Procedures. 4. Reference checks are to be conducted before actual employment begins."<br><br>The Administrator and Director of Nursing were made aware of the findings on 3/4/15 at approximately 10:30 a.m.<br><br>No further information was provided prior to exit. | F 226 | | |
| F 278 SS=E | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than | F 278 | **F278**<br><br>It is the intended practice of this facility to have an assessment that accurately reflects the resident's status.<br><br>**Criteria 1**<br>Resident # 5's MDS was reviewed and corrected.<br><br>Resident #7's MDS was reviewed and corrected.<br><br>Resident #10's MDS was reviewed and corrected.<br><br>Resident #14's MDS was reviewed and corrected. | 04/18/15 |

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| F 278 | Continued From page 5<br>$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure a complete and accurate MDS (minimum data set) assessment for four of 28 residents in the survey sample, Residents #5, #7, #10, and #14.<br><br>1. For Resident #5, the facility staff incorrectly coded the resident as having a fracture that was currently being treated in Section I - Active Diagnoses on the significant change MDS assessment, with an ARD (assessment reference date) of 12/29/14 and the quarterly MDS assessment with an ARD of 12/17/14.<br><br>2. The facility staff failed to accurately code Resident #7's annual MDS with an ARD (assessment reference date) of 12/16/14 to demonstrate the Interview for Daily and Activity Preferences had been attempted.<br><br>3. Resident # 10's significant change MDS (Minimum Data Set) assessment, dated 3/25/14, did not accurately reflect the Resident's height.<br><br>4. Resident # 14's quarterly MDS (Minimum Data | F 278 | **Criteria 2**<br>All residents have the potential to be affected.<br><br>Resident's MDSs will be reviewed for quarterly, annual and significant change for coding of Sections I, F, and K.<br><br>**Criteria 3**<br>IDT team has been re-educated by MDS/designee on accuracy of coding on the MDS.<br><br>**Criteria 4**<br>The IDT team will review resident's MDS during quarterly, annual and significant change assessments.<br><br>The ADNS/designee will randomly audit residents MDS for coding related to active diagnoses, swallowing/nutritional status, and activity residents' interview weekly x4weeks and monthly x2 months and report to QAA committee for review and recommendations.<br><br>**Criteria 5**<br>The facilities alleged date of compliance is April 18, 2015. | |

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| F 278 | Continued From page 6 | F 278 | | |

Set) assessment, dated 10/26/14, did not accurately reflect the Resident's height.

The findings include:

1. For Resident #5, the facility staff incorrectly coded the resident as having a fracture that was currently being treated in Section I - Active Diagnoses on the significant change MDS assessment, with an ARD (assessment reference date) of 12/29/14 and the quarterly MDS assessment with an ARD of 12/17/14.

Resident #5 was admitted to the facility on 9/8/14 with a recent readmission on 10/18/14 with diagnoses that included but were not limited to: anxiety, skin infection, altered mental status, adult failure to thrive, dementia, chronic obstructive pulmonary disease, congestive heart failure, high blood pressure, deep vein thrombosis, and inflammation of the gallbladder.

The most recent MDS assessment, a significant change assessment, with an ARD (assessment reference date) of 12/29/14, coded the resident as being moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for all of her activities of daily living.

The MDS assessment, a quarterly assessment, with an ARD of 12/17/14, coded the resident in Section I - Active Diagnoses as having an "Other Fracture."

The significant change assessment, with an ARD of 12/29/14, coded the resident is Section I - Active Diagnoses as having an "Other Fracture."

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| F 278 | Continued From page 7<br>Review of the clinical record did not reveal any documentation regarding another fracture.<br><br>An interview was conducted with RN (registered nurse) #1, the MDS coordinator, on 3/4/15 at 9:01 a.m. regarding what other fracture Resident #5 had present. RN #1 stated, "She had a lumbar vertebrae fracture in September 2014." When asked if the resident should be coded for this fracture on the significant change MDS with an ARD of 12/29/14 and the quarterly MDS assessment with an ARD date of 12/17/14. RN #1 stated, "Not if she isn't being treated for it."<br><br>An interview was conducted with RN #2, an MDS coordinator; on 3/4/15 at 9:07 a.m. RN #2 was present during the interview with RN #1. RN #2 pulled out her worksheets used for completing both of the MDS assessments for Resident #5 in December 2014. RN #2 stated, "I think it's an error on my part. I even have a note that I was to remove that diagnosis as she was no longer being treated for the lumbar fractures. My mistake."<br><br>CMS RAI Manual October 2014:<br>2. Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses. | F 278 | | |

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| F 278 | Continued From page 8 | F 278 | | |

The administrator and director of nursing were made aware of the above findings on 3/4/15 at 11:06 a.m.
2. The facility staff failed to accurately code Resident #7's annual MDS with an ARD (assessment reference date) of 12/16/14 to demonstrate the Interview for Daily and Activity Preferences had been attempted.

Resident #7 was admitted to the facility on 10/20/11 and most recently readmitted on 2/11/15 with diagnoses that included but were not limited to: osteoporosis, pneumonia and glaucoma. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/18/15, coded the resident's cognition as being severely impaired.

Section B0700 of Resident #7's annual MDS with an ARD of 12/16/14 coded the resident as being understood and as understanding verbal content.

Section F0300 documented, "Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other. 0. No (resident is rarely/never understood and family/significant other not available..." The Staff Assessment of Daily and Activity Preferences was completed.

On 3/4/15 at 10:10 a.m., an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 stated the activities department was responsible for completing Section F of residents' MDS assessments. RN #1 stated if the resident is interviewable then the

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| F 278 | Continued From page 9<br>staff talks to the resident and if not then they complete the staff assessment. RN #1 was asked how staff determines if a resident is interviewable and if this determination was based on any other section of the MDS assessment. RN #1 stated, "Section B. If they are usually or sometimes understood, they can attempt the interview."<br><br>On 3/4/15 at 10:20 a.m., an interview was conducted with OSM (other staff member) #5, the activities director. OSM #5 was asked how she determines if a resident is interviewable. OSM #5 stated, "If they are familiar with their activities and routines and give sensible answers." OSM #5 was asked if Resident #7 was interviewable. OSM #5 stated, "Yes. She is confused and may not be able to tell you where she lives but she is interviewable for preferences." OSM #5 was shown Resident #7's 12/16/14 MDS annual assessment and asked why the Interview for Daily and Activity Preferences was not attempted. OSM #5 stated she attempted the interview with Resident #7 but if there are three questions that the resident doesn't answer then she completes the staff assessment. OSM #5 was asked how F0300 of Resident #7's 12/16/14 MDS was coded. OSM #5 stated, "0. That's not true. It's incorrect. She should be coded 1. Yes." OSM #5 stated she refers to the CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments.<br><br>On 3/4/15 at 11:00 a.m., the administrator and director of nursing were made aware of the above findings.<br><br>The CMS RAI manual documents the following: | F 278 | | |

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| F 278 | Continued From page 10<br><br>"SECTION F: PREFERENCES FOR CUSTOMARY ROUTINE AND ACTIVITIES<br>Intent: The intent of items in this section is to obtain information regarding the resident's preferences for his or her daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. The information obtained during this interview is just a portion of the assessment. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences, and is not meant to be all-inclusive.<br>F0300: Should Interview for Daily and Activity Preferences Be Conducted?<br>Coding Instructions<br>Record whether the resident preference interview should be attempted.<br>· Code 0, no: if the interview should not be attempted with the resident. This option should be selected for residents who are rarely/never understood, who need an interpreter but one was not available, and who do not have a family member or significant other available for interview. Skip to F0800, (Staff Assessment of Daily and Activity Preferences).<br>Code 1, yes: if the resident interview should be attempted. This option should be selected for residents who are able to be understood, for whom an interpreter is not needed or is present, or who have a family member or significant other available for interview. Continue to F0400 (Interview for Daily Preferences) and F0500 (Interview for Activity Preferences)..."<br><br>No further information was presented prior to exit. | F 278 | | |

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3. Resident # 10's significant change MDS (Minimum Data Set) assessment, dated 3/25/14, did not accurately reflect the Resident's height.

Resident #10 was admitted to the facility on 7/23/09 and again on 5/31/14 with diagnoses that included: anemia (low iron), heart failure, hypertension (high blood pressure), diabetes mellitus (high blood sugar), hyperlipidemia (high cholesterol), anxiety, depression, schizophrenia, asthma (disease that affects breathing), altered mental status, kidney disease, obesity and pain.

Resident # 10's most recent comprehensive MDS (minimum data set) a significant change assessment, with an assessment reference date (ARD) of 3/25/14, coded the resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact. The resident was coded as requiring extensive assistance of one staff member for all activities of daily living. In Section K: Swallowing/Nutritional Status, under K0200: Height and Weight, Resident # 10 was coded as being 64 inches tall.

During a clinical record review the most current MDS a quarterly assessment was compared to the most recent comprehensive MDS, a significant change assessment with an ARD of 3/25/14. The most recent MDS was a quarterly assessment with an ARD of 12/15/14. When comparing Section K: Swallowing/Nutritional Status, under K0200: Height and Weight, Resident # 10 was coded as being 62 inches tall.

During an interview on 3/4/15 at approximately 2:45 p.m. with RN (registered nurse) #2, the MDS

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| F 278 | Continued From page 12 | F 278 | | |

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coordinator, regarding the inconsistent height for Resident #10, RN #2 stated, "The nurses input the resident's height."

On 3/4/15 an interview was conducted at approximately 2:50 p.m. with RN # 3, the nursing supervisor. When asked to describe the procedure for obtaining a resident's height, RN #3 stated, "If the resident is able to stand they are measured from head to toe. If they are unable to stand we measure their arm span from finger tip to finger tip." When asked how often a resident's height is measured, RN #3 stated, "On admission and if readmitted." RN #3 was then asked to review Resident #10's heights documented on the comprehensive significant change MDS assessment, with an assessment reference date (ARD) of 3/25/14 and the quarterly MDS assessment with the ARD of 12/15/14. When asked why there was a discrepancy of coding for Resident #10's heights from 64 to 62 inches, RN #3 stated, "I don't think there is a discrepancy."

On 3/4/15 an interview was conducted at approximately 3:20 p.m. with the DON (director of nursing) regarding Resident #10's height. The DON was asked to review Resident #10's heights documented on the comprehensive significant change MDS assessment, with an assessment reference date ARD of 3/25/14 and the quarterly MDS assessment with the ARD of 12/15/14. When asked why there was a discrepancy of coding for Resident #10's heights from 64 to 62 inches, the DON stated, "In November 2014 we re-measured all the residents." When asked why there was a discrepancy in Resident #10's height, the DON stated, "People shrink over time." The DON further stated that Resident #10's initial height of 64 inches was taken in 2010 and had

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| F 278 | Continued From page 13<br>not been re-measured for height until November 2011.<br><br>Review of the facility policy "System for Obtaining Height and Weight" documented in part, "Obtain height on admission and yearly. Height is actually measured not estimated."<br><br>The Administrator and DON were made aware of the findings on 3/4/15 at approximately 4:30 p.m.<br><br>No further information was provided prior to exit.<br><br>4. Resident # 14's quarterly MDS (Minimum Data Set) assessment, dated 10/26/14, did not accurately reflect the Resident's height.<br><br>Resident #14 was admitted to the facility on 1/11/13 and again on 1/16/14 with diagnoses that included: anemia (low iron), heart failure, hypertension (high blood pressure), renal insufficiency (kidney disease), diabetes mellitus (high blood sugar), thyroid disorder, cardiac pacemaker and toe amputation.<br><br>Resident # 14's most recent comprehensive MDS (minimum data set) an annual assessment, with an assessment reference date (ARD) of 1/24/15, coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, with 15 being cognitively intact. The resident was coded as requiring extensive assistance of one staff member for all activities of daily living. In Section K: Swallowing/Nutritional Status, under K0200: Height and Weight, Resident # 14 was coded as being 70 inches tall.<br><br>During a clinical record review the most current MDS a quarterly assessment was compared to | F 278 | | |

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| F 278 | Continued From page 14<br>the most recent comprehensive MDS, an annual assessment with an ARD of 1/24/15. The most recent MDS was a quarterly assessment with an ARD of 10/26/14. When comparing Section K: Swallowing/Nutritional Status, under K0200: Height and Weight, Resident # 14 was coded as being 72 inches tall.<br><br>During an interview on 3/4/15 at approximately 2:45 p.m. with RN (registered nurse) #2, the MDS coordinator, regarding the inconsistent height for Resident #14, RN #2 stated, "The nurses input the resident's height."<br><br>On 3/4/15 an interview was conducted at approximately 2:50 p.m. with RN # 3, the nursing supervisor. When asked to describe the procedure for obtaining a resident's height, RN #3 stated, "If the resident is able to stand they are measured from head to toe. If they are unable to stand we measure their arm span from finger tip to finger tip." When asked how often a resident's height is measured, RN #3 stated, "On admission and if readmitted." RN #3 was then asked to review Resident #14's heights documented on the comprehensive annual MDS assessment, with an ARD of 1/24/15 and the quarterly MDS assessment with the ARD of 10/26/14. When asked why there was a discrepancy of Resident #14's heights from 72 to 70 inches, RN #3 stated, "I don't think there is a discrepancy."<br><br>On 3/4/15 an interview was conducted at approximately 3:20 p.m. with the DON (director of nursing) regarding Resident #14's height. The DON was asked to review Resident #14's heights documented on the comprehensive annual MDS assessment, with an ARD of 1/24/15 and the quarterly MDS assessment with the ARD of | F 278 | | |

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| F 278 | Continued From page 15<br>10/26/14. When asked why there was a discrepancy of Resident #14's heights from 72 to 70 inches the DON stated, "In November 2014 we re-measured all the residents." When asked why there was a discrepancy in Resident #14's height the DON stated, "People shrink over time."<br><br>Review of the facility policy "System for Obtaining Height and Weight" documented in part, "Obtain height on admission and yearly. Height is actually measured not estimated."<br><br>The Administrator and DON were made aware of the findings on 3/4/15 at approximately 4:30 p.m.<br><br>No further information was provided prior to exit. | F 278 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment | F 279 | F279<br>It is the intended practice of the facility to develop, review and revise the resident's comprehensive plan of care.<br><br>Criteria 1<br>Resident #5 has a revised care plan to address cognition or dementia. | 04/18/15 |

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| F 279 | Continued From page 16<br>under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to develop a care plan for one of 28 residents in the survey sample, Resident #5.<br><br>The facility staff failed to develop a care plan to address cognitive loss/dementia that was triggered on the CAA (Care Area Assessment) of the significant change MDS (minimum data set) assessment, with an ARD (assessment reference date) of 12/29/14, for Resident #5.<br><br>The findings include:<br><br>Resident #5 was admitted to the facility on 9/8/14 with a recent readmission on 10/18/14 with diagnoses that included but were not limited to: anxiety, skin infection, altered mental status, adult failure to thrive, dementia, chronic obstructive pulmonary disease, congestive heart failure, high blood pressure, deep vein thrombosis, and inflammation of the gallbladder.<br><br>The most recent MDS (Minimum Data Set) was a significant change assessment, with an ARD (assessment reference date) of 12/29/14, and coded Resident #5 as being moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for all of her activities of daily living.<br><br>In Section V - Care Area Assessment Summary, on the significant change assessment, with an | F 279 | <u>Criteria 2</u><br>All residents have the potential to be affected.<br><br>CAAs will be reviewed to ensure that care plans are initiated for all triggered areas.<br><br><u>Criteria 3</u><br>IDT team has been reeducated by MDS/designee on initiation of resident's care plans based on triggered areas on CAAs.<br><br><u>Criteria 4</u><br>The ADNS/designee will randomly audit resident's care plans based on triggered areas on CAAs weekly x4 weeks and monthly x2 months and report to QAA committee for review and recommendations.<br><br><u>Criteria 5</u><br>The facilities alleged date of compliance is April 18, 2015. | |

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ARD (assessment reference date) of 12/29/14, the resident was checked under column, "Care Area Triggered" for cognitive loss/dementia. The column, "Care Planning Decision" was also checked with an "X," indicating that the triggered area was to be care planned for this resident.

Review of the comprehensive care plan dated, 10/20/14, and reviewed on 1/12/15, did not reveal a care plan to address the resident's cognitive loss/dementia.

An interview was conducted with RN (registered nurse) #1, the MDS coordinator, on 3/4/15 at 9:10 a.m. RN #1 was asked to review Resident #5's care plan and locate on the care plan addressing cognition or dementia. RN #1 reviewed the care plan. She then stated she didn't see it. When asked who is responsible for completing the section of the MDS that includes the cognition, RN #1 stated, "The social workers do that section."

An interview was conducted with other staff member (OSM) #7, the social worker on 3/4/15 at 9:17 a.m. OSM #7 was asked to review the care plan and the significant assessment with and ARD of 12/29/14 and to locate where the care plan addresses cognition/dementia for Resident #5. OSM #7 reviewed the care plan and MDS and stated, "You are correct, it's not there." When asked should cognition/dementia be care planned for this resident, OSM #7 stated, "If it is triggered, and we checked that we were going to care plan it, it should be care planned."

The RAI Manual October 2014:
Coding Instructions for V0200A, CAAs
Facility staff is to use the RAI triggering

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| F 279 | Continued From page 18<br>mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation<br><br>For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision's column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed. For each triggered care area, indicate the date and location of the CAA documentation in the "Location and Date of CAA Documentation" column. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.<br><br>The administrator and director of nursing were made aware of the above findings on 3/4/15 at 11:06 a.m. | F 279 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP | F 280 | | |

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| F 280 | Continued From page 19<br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, 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 two of 28 residents in the survey sample, Residents #9 and #7.<br><br>1. The facility staff failed to review and revise Resident #9's comprehensive care plan following falls on 11/15/14 and 11/19/14.<br><br>2. The facility staff failed to review and revise Resident #7's comprehensive care plan to reflect the removal of fall mats from the resident's room. | F 280 | F280<br>It is the intended practice of the facility to develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a RN with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>Criteria 1<br>Resident #9 has a revised care plan to address fall prevention.<br><br>Resident #7 has a revised care plan to address the removal of fall mats.<br><br>Criteria 2<br>All residents have the potential to be affected.<br><br>Residents with falls will be reviewed in Eagle Room for care plan revisions sand updated as appropriate.<br><br>Criteria 3<br>IDT team has been reeducated by MDS/designee on revision of resident's care plans. | 04/18/15 |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 280 | Continued From page 20<br>The findings include:<br><br>1. Resident #9 was admitted to the facility on 8/26/14 and most recently readmitted on 9/9/14 with diagnoses including, but not limited to: dementia, depression, high blood pressure, psychosis and benign prostate enlargement. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date of 12/17/14, Resident #9 was coded as being severely cognitively impaired for making daily decisions. He was coded as being independent for walking, and as requiring the assistance of staff for bed mobility, toileting, personal hygiene and bathing. He was coded as having one fall with no injury and one fall with minor injury during the look-back period.<br><br>A review of the nurses' notes for Resident #9 revealed the following note written on 11/15/14 at 1:02 p.m.: "Resident was laid in the bed for a nap because resident appeared to be sleepy and exhausted. Resident did not sleep at night. Resident is continuously pace (sic) the hallway pushing the two exit doors seeking to go out. Resident has difficulty walking. Resident is a high risk of falling. Resident is very difficult to redirect. Resident has three abrasions: on the rt. (right) forehead, above rt. eyebrow and rt. lower back. Resident also has a cut on the lt. (left) eyebrow. [Name of physician] and R/P (responsible party) were made aware. Son said he will take resident to the [name of local hospital]. Neuro (neurological) checks within normal limits, moving all extremities. Resident a/o (alert and oriented) to person. Resident's condition is stable. No resp. (respiratory) distress. Resident is walking as usual." | F 280 | **Criteria 4**<br>The ADNS/designee will randomly audit resident's care plans related to falls weekly x4 weeks and monthly x2 months and report to QAA committee for review and recommendations.<br><br>**Criteria 5**<br>The facilities alleged date of compliance is April 18, 2015. | |

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| F 280 | Continued From page 21<br>A review of the fall investigation dated 11/15/14 revealed that the facility staff discovered blood on the corner of the resident's night stand and on the floor between the bed and the nightstand. The review revealed that the facility staff treated this incident as a fall because he had been observed lying in bed just prior to the fall, and because of the presence of the blood on the nightstand corner.<br><br>On 3/4/15 at 12:20 p.m., LPN (licensed practical nurse) #4 was interviewed regarding this fall. She stated that Resident #9 was "very tired" and "looked like he needed a nap." She stated that she remembered that a staff member assisted Resident #9 into his bed. She stated that the next time she saw the resident; he was walking down the hall as described in her note.<br><br>A review of Emergency Room discharge instructions for Resident #9 dated 11/15/14 revealed instructions to care for three stitches that had been placed over the resident's left eyebrow.<br><br>Further review revealed the following note written on 11/19/14 at 11:15 p.m.: "At start of shift, CNA (certified nursing assistant) was making rounds and assisted [Resident #9] back to bed and closed the door. Approx (approximately) four min. (minutes) later CNA heard a loud noise coming from dining area and went to assess. CNA observed [Resident #9] sitting on the floor beside chair. CNA than (sic) went to get Charge nurse. Charge nurse assess (sic) resident for pain/injury with none noted. Resident denies hitting head. Neuro checks initiated and within normal limits. Resident assisted to standing position and assisted to sit in chair and offered a | F 280 | | |

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| F 280 | Continued From page 22 | F 280 | | |

snack. MD (doctor) is aware. Called RP two times with message left to call back to facility."

A review of the comprehensive care plan dated 9/17/14 and most recently updated on 1/22/15 revealed the following interventions for falls prior to the 11/15/14 fall: "Bed in low position . . . Provide assist to transfer and ambulate as needed . . . Therapy evaluation and treatment per orders. Attempt to redirect resident when he is restless." A review of the facility investigations for the 11/15/14 and 11/19/14 falls revealed that the resident's bed was in low position on last observation by a staff member, and that the resident had been assisted to bed by a CNA just prior to both falls. A review of the clinical record also revealed therapy evaluations and treatment prior to the falls to strengthen Resident #9's ability to walk without difficulties. At the time of these falls, Resident #9 had been discharged from therapy services with no recommendations for supervision for ambulation.

However, a review of this care plan revealed no reviews or new interventions following the above referenced falls.

On 3/4/15 at 12:20 p.m., LPN (licensed practical nurse) #4, who was working on the unit where Resident #9 resides, was interviewed regarding the process of updating care plans after a fall. She stated that everyone is responsible for updating the care plan, including the nurse working at the time of the fall, the unit manager, the ADON (assistant director of nursing) and the DON (director of nursing). When shown the documentation regarding these two falls and the care plan, LPN #4 stated, "I don't know what happened. I can't say why I didn't update the

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| F 280 | Continued From page 23<br>care plan. I don't know."<br><br>On 3/4/15 at 2:05 p.m., ASM (administrative staff member) #2, the director of nursing (DON), and ASM #3, the assistant director of nursing (ADON), were interviewed regarding the process of updating care plans after a fall. ASM #3 stated that the charge nurse is responsible for updating the care plan. She stated that the she was in the process of determining why these care plans were not updated. She stated that the facility staff usually does a very good job of updating the care plans with any changes in a resident's status. ASM #2 stated that she did not know why the care plans were not updated. She described the facility's practice of twice-a-day "Eagle Room" meetings at which resident incidents/status changes are discussed and interventions are planned. She stated she remembered discussing these falls in the Eagle Room, but admitted that there was no documentation of these discussions in the resident's record.<br><br>On 3/4/15 at 3:20 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. Policies and procedures regarding care plan updates and falls were requested. ASM #2 stated that anything related to updating a care plan after a fall would be contained in the falls policy.<br><br>A review of the facility policy entitled "Falls Practice Guide" revealed, in part, the following: "Following review of risk factors, environmental factors and other clinical conditions, the patient's initial care plan is updated or a comprehensive care plan is developed to include individualized patient interventions that focus on the patient's risk factors." | F 280 | | |

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| F 280 | Continued From page 24 | F 280 | | |

Nothing further was provided prior to exit.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

2. The facility staff failed to review and revise Resident #7's comprehensive care plan to reflect the removal of fall mats from the resident's room.

Resident #7 was admitted to the facility on 10/20/11 and most recently readmitted on 2/11/15 with diagnoses that included but were not limited to: osteoporosis, pneumonia and glaucoma. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/18/15, coded the resident's cognition as being severely impaired.

Review of Resident #7's clinical record revealed a comprehensive care plan initiated on 1/23/14 and revised on 7/21/14. The care plan documented, "Goal: Minimize risk for falls. Interventions: Bed

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| F 280 | Continued From page 25<br>in low position when occupied. Bilateral floor mats. PDM (perimeter defined mattress [with raised edges around the perimeter] mattress to aid in defining perimeters..."<br><br>Observations of Resident #7 in a low bed with a PDM mattress was conducted on 3/3/15 at 3:45 p.m. and 3/4/15 at 8:34 a.m. No fall mats were observed by the bed or anywhere in the room.<br><br>On 3/4/15 at 9:20 a.m., an interview was conducted with RN (registered nurse) #3, the unit manager. RN #3 was asked to describe the fall prevention interventions in place for Resident #7. RN #3 reviewed the resident's care plan and stated, "Low bed. Fall mats." At this time, RN #3 was asked to walk with this surveyor to Resident #7's room. RN #3 was asked where Resident #7's fall mats were. RN #3 stated the fall mats were removed when Resident #7 was provided a scoop mattress ( PDM mattress) and the fall mats needed to be removed from the resident's care plan.<br><br>On 3/4/15 at 11:00 a.m., the administrator and director of nursing were made aware of the above findings.<br><br>The facility policy document, "PHASE 1 ASSESS" documented, "COMPREHENSIVE CARE PLAN: The approaches for fall interventions are clear, specific and individualized for the patient's needs. Managing falls can be complex as many falls do not have a single cause but include a combination of risk factors and causes. Regardless of the interventions that are put into place, a key factor to success is the timely review of the interventions as the patient's condition and needs change..." | F 280 | | |

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| F 280 | Continued From page 26<br><br>On 3/4/15 at 2:10 p.m., the administrator provided a copy of Resident #7's updated care plan. The administrator confirmed the fall mats were resolved from the care plan after this surveyor's interview with RN #3.<br><br>No further information was presented prior to exit. | F 280 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to follow professional standards of practice during medication administration on 1 of 5 nursing units (the 600 unit).<br><br>LPN (licensed practical nurse) #2 left medications on top of the medication cart and the cart unlocked and unsupervised during the medication pass observation on the 600 unit.<br><br>The findings include:<br><br>On 3/3/15 at 5:05 p.m., the surveyor arrived on the 600 nursing unit for the medication administration observation. A medication cart was observed in the hallway, against the wall, the drawers/front side facing out towards the open hallway. The cart was observed unlocked. An inverted drinking cup was on top of the cart. | F 281 | F281<br><br>It is the intended practice of the facility to provide services that meet professional standards of quality.<br><br>Criteria 1<br>Incident report completed for Resident #19. MD notified with no new orders.<br><br>Resident #20 received her medications as ordered.<br><br>LPN#2 educated on not leaving medications unsupervised and on not leaving medication cart unlocked during medication administration to ensure the safety of Residents #27 and #28. | 04/18/15 |

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| F 281 | Continued From page 27<br>Under this cup were the following medications: *hydrocodone 7.5 mg, (milligrams) (a narcotic pain medication), *potassium 20 meq (milliequivalents) (used for potassium replacement), and *hydralazine 25 mg. (used to treat high blood pressure) (the medications were for Resident #20).<br><br>On 3/3/15 at 5:07 p.m., a staff member (social services) walked by the cart and pushed in a drawer that was slightly cracked open.<br><br>On 3/3/15 at 5:08 p.m., Resident #27 went past the cart in her wheelchair.<br><br>On 3/3/15 at 5:10 p.m., LPN #2 (Licensed Practical Nurse #2) returned to the cart.<br><br>At this time (5:11 p.m.), LPN #2 moved the cart down the hall to the room of Resident #19, turning the cart so the drawers faced towards the resident's room, in the doorway of the room. LPN #2 was observed pulling the lock on the cart out all the way with his hand, and did not attempt to use a key to unlock the cart, indicating the cart was not locked. LPN #2 was observed preparing medications for another resident (Resident #19). The inverted drinking cup containing medications remained on top of the cart. He picked the cup up, and in doing so, clearly revealed that a medication cup containing pills was under the drinking cup. When asked what resident the medications were for, he stated, "(name of Resident #20)." At this time, he prepared the following medications for Resident #19: *Neurontin 300 mg (used to treat neuropathy), *Nexium 40 mg (used to treat GERD), *Oxycodone 10 mg (narcotic pain medication), and **Miralax (a heaping cap full) (used to treat | F 281 | **Criteria 2**<br>All residents have the potential to be affected.<br><br>Reeducate the nursing staff on not leaving medications unsupervised and on not leaving medication cart unlocked while unattended.<br><br>**Criteria 3**<br>LPN #2 on not leaving medications unsupervised and on not leaving medication cart unlocked while unattended.<br><br>Nurses have been reeducated on not leaving medications unsupervised and on not leaving medication cart unlocked while unattended.<br><br>**Criteria 4**<br>ADNS/designee will randomly audit medication administration weekly x4 weeks and monthly x2 months and report to QAA committee for review and recommendations.<br><br>**Criteria 5**<br>The facilities alleged date of compliance is April 18, 2015. | |

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constipation). He then searched the cart for *Tylenol (used to treat pain) and was not able to locate any for the resident. He then placed an inverted drinking up over the cup of medications, (now having 2 inverted drinking cups covering medications on top of the cart - for Resident #20 and #19), and left the cart unsupervised and unlocked to obtain the Tylenol from the stat box. This was approximately 5:20 p.m. At approximately 5:23 p.m., LPN #2 returned to the cart and administered the prepared medications to Resident #19.

After administering medications to Resident #19, LPN #2 was observed placing the medications for Resident #20 inside the medication cart. LPN #2 then moved the cart down to the room for Resident #28 (approximately 5:26 p.m.). LPN #2 placed the medication cart in front of the room for Resident #28, the cart was positioned in the doorway facing into the resident's room. He then prepared the following medications for Resident #28: *aspirin 81 mg (used to prevent blood clots), *Tylenol 650 mg, and ***Thera M multivitamin (for vitamin deficiency). He was observed searching the medication cart for *caltrate with Vitamin D (used to replace calcium and vitamin D) to administer the resident but was unable to locate it. He then left the cart again, to search the medication room for caltrate at approximately 5:30 p.m.. LPN #2 left the cart unlocked and unsupervised. He returned to the cart at approximately 5:36 p.m.

On 3/4/15 at 3:08 p.m., an interview was conducted with LPN #2. He stated he was nervous about being watched and should not have left meds (medications) on top of the cart, unattended or the cart unlocked. When it was

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| F 281 | Continued From page 29<br>discussed that the cart was unlocked and medications were unsupervised on top of it when the surveyor initially approached the cart, and LPN #2 was not present, he made no comment.<br><br>A review of the facility policy "Medication Administration: Medication Pass" documented, ".....lock medication cart when not in direct view of nurse administering medication..." A review of the facility policy "Medication and Treatment Administration Guidelines", documented, "...Medications and biologicals are securely stored in a locked cabinet, cart or medication room, accessible only to licensed nursing staff and maintained under a lock system when not actively utilized and attended to by nursing staff for medication administration...."<br><br>On 3/4/15 at 3:41 p.m., the Director of Nursing and Assistant Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.<br><br>Resident #20 was admitted to the facility on 2/15/08 with the diagnoses of but not limited to leg amputation, high blood pressure, osteoporosis, and coronary artery disease. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 2/22/15. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring limited assistance for dressing and supervision for transfers, eating, and hygiene.<br><br>Resident #27 was admitted to the facility to 10/19/14 with the diagnoses of but not limited to diabetes, high blood pressure, schizophrenia, depression, and deep vein thrombosis. The most | F 281 | | |

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| F 281 | Continued From page 30<br>recent MDS coded Resident #27 as cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing, dressing, and bed mobility; limited assistance for transfers out of bed; and supervision for eating and hygiene.<br><br>Resident #19 was admitted to the facility on 8/25/14 with the diagnoses of but not limited to paraplegia, chronic obstructive pulmonary disease, high blood pressure, and a pressure sore. The most recent MDS was an annual assessment with an ARD of 2/8/15. The resident was coded as cognitively intact in ability to make daily life decisions; and was coded as requiring extensive assistance for bathing, hygiene, dressing, and transfers; and limited assistance for eating.<br><br>Resident #28 was admitted to the facility on 12/18/13 with the diagnoses of but not limited to high blood pressure, arthritis, thromboembolus, and deep vein thrombosis. The most recent MDS was an annual assessment with an ARD of 12/27/14. The resident was coded as severely cognitively impaired in ability to make daily life decisions; and was coded as requiring total assistance for transfers out of bed; extensive assistance for bed mobility, dressing, and hygiene; and supervision for eating.<br><br>According to "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 703. "Make sure that all medications are in locked containers in a room (e.g., medication room) or are under constant surveillance."<br><br>According to information obtained from | F 281 | | |

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| F 281 | Continued From page 31<br>Fundamentals of Nursing: Concepts, Process, and Practice, 4th ed. St Louis: Mosby-Year Book, Inc., page 376, by Potter, Patricia A., and Anne Griffin Perry: "Medications of any sort should not be left unattended, and patients should be observed taking the medication."<br><br>According to Fundamentals of Nursing, 6th edition, 2001: Patricia A. Potter and Anne Griffen Perry; Mosby, Inc., page 828, "Guidelines for Safe Narcotic Administration and Control: Store all narcotics in a locked, secure cabinet or container."<br><br>*Information obtained from Nurse's Drug Guide 2009, Prentice Hall, pages 9, 222, 593, 698, 752, 755, 1152, and 1259<br><br>**Information obtained from http://www.nlm.nih.gov/medlineplus/druginfo/meds/a603032.html<br><br>***Information obtained from http://www.pharmacyhealth.net/d/thera-m-vitamins-8274.htm | F 281 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced | F 309 | F309<br><br>It is the intended practice of this facility to have each resident receive and the facility provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | 04/18/15 |

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| F 309 | Continued From page 32<br>by:<br>Based on staff interview, facility document review, clinical record review, it was determined that the facility staff failed to perform a complete pain assessment for one of 28 residents in the survey sample, Resident #5.<br><br>The facility staff failed to offer non-pharmacological interventions prior to the administration of as needed pain medications and failed to assess Resident #5's pain using quality descriptors (such as non-verbal gestures, quality, onset, duration or intensity of pain) before the administration of as needed pain medication in January 2015.<br><br>The findings include:<br><br>Resident #5 was admitted to the facility on 9/8/14 with a recent readmission on 10/18/14 with diagnoses that included but were not limited to: anxiety, skin infection, altered mental status, adult failure to thrive, dementia, chronic obstructive pulmonary disease, congestive heart failure, high blood pressure, deep vein thrombosis, and inflammation of the gallbladder.<br><br>The most recent MDS (Minimum Data Set) assessment, a significant change assessment, with an ARD (assessment reference date) of 12/29/14, coded the resident as being moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for all of her activities of daily living.<br><br>The physician orders for January 2015, and signed by the physician on 1/11/15, documented, | F 309 | **Criteria 1**<br>Resident #5's comprehensive pain assessment completed and care plan updated with non-pharmacological interventions.<br><br>**Criteria 2**<br>Residents at risk for pain will be identified and reevaluated with measurable criteria, quality descriptors for pain, and non – pharmacological interventions prior to administration of pain medication and reassessed for effectiveness of non-pharmacological interventions and medication administration.<br><br>**Criteria 3**<br>Nurses have been reeducated on our Pain Practice Guide, to include, but not limited to: medication administration/documentation, following physician orders, usage of non-pharmacological interventions prior to medication administration and reassessment using quality indicators.<br><br>**Criteria 4**<br>ADNS/designee will randomly audit pain assessments for completion weekly x4 weeks and monthly x2 months and report to QAA committee for review and recommendations.<br><br>**Criteria 5**<br>The facilities alleged date of compliance is April 18, 2015. | |

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| F 309 | Continued From page 33<br>"MAPAP (Tylenol) 325 mg (milligrams) tablet; 1 tabs (tablet) by mouth twice daily for pain." This is a scheduled medication. A second physician order documented, "MAPAP (Tylenol) 2 tabs (650 mg) by mouth every 6 hours as needed for elevated temperature."<br><br>Review of the January MAR (medication administration record) revealed documented, "MAPAP (Tylenol) 2 tabs (650 mg) by mouth every 6 hours as needed for elevated temperature." It was documented as having been given on 1/28/15 at 11:08 a.m. and 1/31/15 at 12:30 p.m. The reverse of the MAR did not reveal any documentation regarding the administration of Tylenol.<br><br>Review of the nurse's notes for 1/28/15 and 1/31/15 did not document the administration of Tylenol, the reason for it, if non pharmacologic interventions were provided or the effectiveness of the medication after receiving it.<br><br>The comprehensive care plan, dated, 1/2/15, documented, "Focus: right heel pain... " The "Interventions" documented, "Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. Administer pain medication per physician orders. Encourage/Assist to reposition frequently to position of comfort."<br><br>An interview was conducted with RN (registered nurse) #4 on 3/4/15 at 10:00 a.m. regarding what procedure the nursing staff should follow when a resident complains of pain. RN #4 stated, "First they need to assess the resident for the location, intensity, and pain level and then offer non-pharmacologic interventions, like | F 309 | | |

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| F 309 | Continued From page 34 repositioning. Give the pain medication. The nurse has to go back and reassess the resident to see if the medication is effective." When asked where all of the assessment, non-pharmacologic interventions and medication are documented, RN #4 stated, "It should be documented on the MAR." When asked where the non-pharmacologic interventions are documented, RN #4 stated, "They should write a nurse's note in (name of computer program)." RN #4 was then asked to review the MAR and the nurse's notes regarding the administration of Tylenol to Resident #5. RN #4 reviewed the MAR and nurses notes and stated, "I don't see it documented except on the front of the MAR." When asked if the documentation on the MAR included the location, intensity, non-pharmacologic interventions and effectiveness of the medications, RN #4 stated, "No, it's not there."<br><br>An interview was conducted with administrative staff member (ASM) #3; the assistant director of nursing, on 3/4/15 at 10:24 a.m. regarding the process nursing should follow when a resident complains of pain. ASM #3 stated, "First the nurse should assess the resident; type, intensity, and location of pain. They should off non-pharmacologic interventions, such as repositioning. Offer pain medication. After a little while reassess the resident to ensure the pain was relieved." When asked where all of the assessment, pain medication administration and the offering of non-pharmacologic interventions is documented, ASM #3 stated, "The nurse can write on the back of the MAR or they can write a nurse's note."<br><br>The facility policy, "Pain Practice Guide" | F 309 | | |

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| F 309 | Continued From page 35<br>documented, "Obtain pain scale scores daily and before and after administration of PRN (as needed) analgesics. Scores are documented on the MAR...Interventions include non-pharmacologic as well as pharmacologic. Non-pharmacologic approaches used as initial interventions can minimize the need for medications, permit use of the lowest does or result in discontinuation of medications."<br><br>"During an episode of acute pain the nurse .. assesses the location, severity and quality of pain." Fundamentals of Nursing, 6th edition, Perry & Potter, page 1241<br><br>The administrator and director of nursing were made aware of the above findings on 3/4/15 at 11:06 a.m. | F 309 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services in a manner to promote safety for two of 28 residents in the survey sample, Resident #9 and #27. | F 323 | F323<br><br>It is the intended practice of this facility to ensure that the resident environments remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>Criteria 1<br>Resident #9 has a revised care plan to address fall prevention.<br><br>LPN#2 educated on not leaving medications unsupervised and on not leaving medication cart unlocked during medication administration to ensure the safety of Resident #27. | 04/18/15 |

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| F 323 | Continued From page 36<br><br>1. The facility staff failed to develop and implement interventions to prevent further falls for Resident #9 following falls on 11/15/14 and 11/19/14.<br><br>2. The facility staff failed to ensure medications were secured in a safe manner on one medication cart on the 600 nursing unit. Resident #27 was observed passing the cart with unsecured and accessible medications in her wheelchair.<br><br>The findings include:<br><br>1. Resident #9 was admitted to the facility on 8/26/14 and most recently readmitted on 9/9/14 with diagnoses including, but not limited to: dementia, depression, high blood pressure, psychosis and benign prostate enlargement. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 12/17/14, Resident #9 was coded as being severely cognitively impaired for making daily decisions. He was coded as being independent for walking, and as requiring the assistance of staff for bed mobility, toileting, personal hygiene and bathing. He was coded as having one fall with no injury and one fall with minor injury during the look-back period.<br><br>A review of the nurses' notes for Resident #9 revealed the following note written on 11/15/14 at 1:02 p.m.: "Resident was laid in the bed for a nap because resident appeared to be sleepy and exhausted. Resident did not sleep at night. Resident is continuously pace (sic) the hallway pushing the two exit doors seeking to go out. Resident has difficulty walking. Resident is a high | F 323 | **Criteria 2**<br>All residents have the potential to be affected.<br><br>Residents with falls will be reviewed in Eagle Room for care plan revisions sand updated as appropriate.<br><br>Nurses have been reeducated on not leaving medications unsupervised and on not leaving medication cart unlocked while unattended.<br><br>**Criteria 3**<br>IDT team has been reeducated by MDS/designee on revision of resident's care plans.<br><br>Nurses have been reeducated on not leaving medications unsupervised and on not leaving medication cart unlocked while unattended.<br><br>**Criteria 4**<br>The ADNS/designee will randomly audit resident's care plans related to falls weekly x4 weeks and monthly x2 months and report to QAA committee for review and recommendations.<br><br>ADNS/designee will randomly audit medication administration weekly x4 weeks and monthly x2 months and report to QAA committee for review and recommendations.<br><br>**Criteria 5**<br>The facilities alleged date of compliance is April 18, 2015. | |

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risk of falling. Resident is very difficult to redirect. Resident has three abrasions: on the rt. (right) forehead, above rt. eyebrow and rt. lower back. Resident also has a cut on the lt. (left) eyebrow. [Name of physician] and R/P (responsible party) were made aware. Son said he will take resident to the [name of local hospital]. Neuro (neurological) checks within normal limits, moving all extremities. Resident a/o (alert and oriented) to person. Resident's condition is stable. No resp. (respiratory) distress. Resident is walking as usual." [The CNA working with Resident #9 at the time of this fall was not available for interview during the survey.]

A review of the fall investigation dated 11/15/14 revealed that the facility staff discovered blood on the corner of the resident's night stand and on the floor between the bed and the nightstand. The review revealed that the facility staff treated this incident as a fall because he had been observed lying in bed just prior to the fall, and because of the presence of the blood on the nightstand corner.

On 3/4/15 at 12:20 p.m., LPN (licensed practical nurse) #4 was interviewed regarding this fall. She stated that Resident #9 was "very tired" and "looked like he needed a nap." She stated that she remembered that a staff member assisted Resident #9 into his bed. She stated that the next time she saw the resident; he was walking down the hall as described in her note.

A review of Emergency Room discharge instructions for Resident #9 dated 11/15/14 revealed instructions to care for three stitches that had been placed over the resident's left eyebrow.

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Further review revealed the following note written on 11/19/14 at 11:15 p.m.: "At start of shift, CNA (certified nursing assistant) was making rounds and assisted [Resident #9] back to bed and closed the door. Approx (approximately) four min. (minutes) later CNA heard a loud noise coming from dining area and went to assess. CNA observed [Resident #9] sitting on the floor beside chair. CNA than (sic) went to get Charge nurse. Charge nurse assess (sic) resident for pain/injury with none noted. Resident denies hitting head. Neuro checks initiated and within normal limits. Resident assisted to standing position and assisted to sit in chair and offered a snack. MD (doctor) is aware. Called RP two times with message left to call back to facility."

A review of the comprehensive care plan dated 9/17/14 and most recently updated on 1/22/15 revealed the following interventions for falls prior to the 11/15/14 fall: "Bed in low position . . . Provide assist to transfer and ambulate as needed . . . Therapy evaluation and treatment per orders. Attempt to redirect resident when he is restless." A review of the facility investigations for the 11/15/14 and 11/19/14 falls revealed that the resident's bed was in low position on last observation by a staff member, and that the resident had been assisted to bed by a CNA just prior to both falls. A review of the clinical record also revealed therapy evaluations and treatment prior to the falls to strengthen Resident #9's ability to walk without difficulties. At the time of these falls, Resident #9 had been discharged from therapy services with no recommendations for supervision for ambulation.

However, a review of this care plan revealed no

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| F 323 | Continued From page 39<br>reviews or new interventions following the above referenced falls.<br><br>On 3/4/15 at 12:20 p.m., LPN (licensed practical nurse) #4, who was working on the unit where Resident #9 resides, was interviewed regarding the process of putting new interventions into place to prevent further falls after a resident sustains a fall. She stated that everyone is responsible for updating the care plan, but that usually the unit manager, the ADON (assistant director of nursing) or the DON (director of nursing) decides on the new interventions. She stated: "I don't know what else to do for him [Resident #9]."<br><br>On 3/4/15 at 2:05 p.m., ASM (administrative staff member) #2, the DON, and ASM #3, the ADON, were interviewed regarding putting new interventions into place to prevent further falls after a resident sustains a fall. ASM #3 stated that the facility staff usually does a very good job of thinking though a resident's care plan and coming up with new interventions to promote safety. She stated she did not understand what had happened in the above referenced instances. ASM #2 was interviewed regarding why the facility staff treated the 11/15/14 incident as a fall. She reiterated what was contained in the above-referenced incident report. She stated that the resident had been observed lying in bed, and that there was blood on the corner of the night stand and on the floor in a pattern consistent with a fall. ASM #2 stated that she could not identify any new interventions in the resident's clinical record. She described the facility's practice of twice-a-day "Eagle Room" meetings at which resident incidents/status changes are discussed and interventions are planned. She stated she | F 323 | | |

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remembered discussing these falls in the Eagle Room, but admitted that there was no documentation of these discussions in the resident's record. ASM #2 was asked to provide a fall risk assessment for Resident #9 prior to the above referenced falls. She stated that she could not provide one because the facility does not perform them.

On 3/4/15 at 3:20 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. Policies and procedures regarding new interventions to promote safety following a fall were requested.

A review of the facility policy entitled "Falls Practice Guide" revealed, in part, the following: "The approaches for fall interventions are clear, specific and individualized for the patient's needs. Managing falls can be complex as many falls do not have a single cause but include a combination of risk factors and causes. Regardless of the interventions that are put into place, a key factor to success is the timely review of the interventions as the patient's condition and needs change."

According to Mosby's Textbook for Long-Term Care Assistants, fourth edition, 2003. Page 144, "Safety is a basic need. Nursing center residents are at great risk for falls and other accidents....You need to know the factors that increase a person's risk of accidents and injury. You also need to follow the person's care plan."

2. The facility staff failed to ensure medications were secured in a safe manner on one

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medication cart on the 600 nursing unit. Resident #27 was observed passing the cart with unsecured and accessible medications in her wheelchair.

Resident #27 was admitted to the facility to 10/19/14 with the diagnoses of but not limited to diabetes, high blood pressure, schizophrenia, depression, and deep vein thrombosis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/26/15. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for dressing and bathing; limited assistance for transfers out of bed; and supervision for eating and hygiene.

Resident #20 was admitted to the facility on 2/15/08 with the diagnoses of but not limited to leg amputation, high blood pressure, osteoporosis, and coronary artery disease. The most recent MDS was an annual assessment with an ARD of 2/22/15. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring limited assistance for dressing and supervision for transfers, eating, and hygiene.

On 3/3/15 at 5:05 p.m., the surveyor arrived on the 600 nursing unit for the medication administration observation. A medication cart was observed in the hallway, against the wall, the drawers/front side facing out towards the open hallway. The cart was observed unlocked. An inverted drinking cup was on top of the cart. Under this cup were the following medications:
*hydrocodone 7.5 mg, (milligrams) (a narcotic

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| F 323 | Continued From page 42<br>pain medication), *potassium 20 meq (milliequivalents) (used for potassium replacement), and *hydralazine 25 mg. (used to treat high blood pressure) (the medications were for Resident #20).<br><br>On 3/3/15 at 5:07 p.m., a staff member (social services) walked by the cart and pushed in a drawer that was slightly cracked open.<br><br>On 3/3/15 at 5:08 p.m., Resident #27 went past the cart in her wheelchair.<br><br>On 3/3/15 at 5:10 p.m., LPN #2 (Licensed Practical Nurse #2) returned to the cart.<br><br>On 3/3/15 at 5:11 p.m., LPN #2 was observed preparing medications for another resident (Resident #19). The inverted drinking cup containing medications remained on top of the cart. He picked the cup up, and in doing so, clearly revealed a medication cup containing pills was under the drinking cup. When asked what resident the medications were for, he stated, "(name of Resident #20)."<br><br>On 3/4/15 at 3:08 p.m., an interview was conducted with LPN #2. He stated he was nervous about being watched and should not have left meds (medications) on top of the cart, unattended or the cart unlocked. When it was discussed that the cart was unlocked and medications were unsupervised on top of it when the surveyor initially approached the cart, and LPN #2 was not present, he made no comment.<br><br>A review of the facility policy "Medication Administration: Medication Pass" documented, | F 323 | | |

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".....lock medication cart when not in direct view of nurse administering medication...". A review of the facility policy "Medication and Treatment Administration Guidelines" documented, "...Medications and biologicals are securely stored in a locked cabinet, cart or medication room, accessible only to licensed nursing staff and maintained under a lock system when not actively utilized and attended to by nursing staff for medication administration...."

On 3/4/15 at 3:41 p.m., the Director of Nursing and Assistant Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.

According to "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 703. "Make sure that all medications are in locked containers in a room (e.g., medication room) or are under constant surveillance."

According to Information obtained from Fundamentals of Nursing: Concepts, Process, and Practice, 4th ed. St Louis: Mosby-Year Book, Inc., page 376, by Potter, Patricia A., and Anne Griffin Perry: "Medications of any sort should not be left unattended, and patients should be observed taking the medication."

According to Fundamentals of Nursing, 6th edition, 2001: Patricia A. Potter and Anne Griffen Perry; Mosby, Inc., page 828, "Guidelines for Safe Narcotic Administration and Control: Store all narcotics in a locked, secure cabinet or container."

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| MANORCARE HEALTH SERVICES-STRATFORD HALL REVISED | 2125 HILLIARD ROAD RICHMOND, VA 23228 |

| (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 |
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| F 323 | Continued From page 44<br>*Information obtained from Nurse's Drug Guide 2009, Prentice Hall, pages 752, 755, and 1259.<br><br>**Information obtained from http://www.nlm.nih.gov/medlineplus/druginfo/meds/a603032.html<br><br>***Information obtained from http://www.pharmacyhealth.net/d/thera-m-vitamins-8274.htm | F 323 | | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to administer oxygen according to physician's orders for three of 28 residents in the survey sample, Residents #7, #11 and #10.<br><br>1. Resident #7 was observed on separate occasions during the survey with the oxygen flow rate set between one liter and two liters per | F 328 | F328<br><br>It is the intended practice of this facility that residents receive the proper treatment and care for the following special services: injections; parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prostheses.<br><br>Criteria 1<br>Resident #7, #11, and #10 oxygen corrected to be administered per physician order. | 04/18/15 |

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| F 328 | Continued From page 45<br>minute; the physician's order was for two liters per minute.<br><br>2. Resident # 13 was observed on separate occasions during the survey with the oxygen flow rate set at 1 1/2 liters per minute and at 3 liters a minute; the physicians order was for oxygen at 2 liters a minute continuously.<br><br>3. Resident #10 was observed on separate occasions during the survey with the oxygen flow rate set between 1.5 and 2.0 L/min (liter/minute); the physician order was for 2L/min.<br><br>The findings include:<br><br>1. Resident #7 was observed on separate occasions during the survey with the oxygen flow rate set between one liter and two liters per minute; the physician's order was for two liters per minute.<br><br>Resident #7 was admitted to the facility on 10/20/11 and most recently readmitted on 2/11/15 with diagnoses that included but were not limited to: osteoporosis, pneumonia and glaucoma. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/18/15, coded the resident's cognition as being severely impaired. Section G coded Resident #7 as requiring extensive assistance of one staff with bed mobility, transfers and locomotion. Section O documented the resident received oxygen therapy during the last 14 days.<br><br>Review of Resident #7's clinical record revealed a physician's order dated 3/2/15 at 4:00 p.m. for oxygen at two liters times 48 hours. Another | F 328 | **Criteria 2**<br>All residents on oxygen was reviewed to validate that they were administered correct dosage of oxygen per physician order.<br><br>**Criteria 3**<br>Licensed nursing staff will be reeducated on reading and verifying oxygen on amount of liters prescribed by physician.<br><br>**Criteria 4**<br>ADNS/designee will randomly audit residents on oxygen weekly x4 weeks and monthly x2 months and report to QAA committee for review and recommendations.<br><br>**Criteria 5**<br>The facilities alleged date of compliance is April 18, 2015. | |

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physician's order dated 3/3/15 at 8:45 p.m. documented an order for oxygen at two liters per minute via nasal cannula* as needed for shortness of breath or an oxygen saturation level** below 90 percent.

Resident #7's comprehensive care plan initiated on 11/29/12 documented, "Goal: I will have no acute respiratory distress. Interventions: Administer oxygen per physician order..."

On 3/3/15 at 3:45 p.m., Resident #7 was observed sitting up in bed with an oxygen nasal cannula on. The oxygen concentrator was set between one liter and two liters as evidenced by the ball in the flow meter between the one liter mark and the two liter mark.

On 3/4/15 at 8:34 a.m., Resident #7 was observed sitting up in bed with a nasal cannula on. The oxygen concentrator was set between one liter and two liters as evidenced by the ball in the flow meter between the one liter mark and the two liter mark.

On 3/4/15 at 9:20 a.m., an interview was conducted with RN (registered nurse) #3. RN #3 was asked where the ball in the oxygen concentrator flow meter should be positioned if a resident has an order for oxygen at two liters. RN #3 stated the middle of the ball should be right on the two line but some fluctuate based on the concentrator. At this time, RN #3 was shown Resident #7's oxygen concentrator. RN #3 stated the flow meter was set at one and a half liters at eye level but two liters if you look up.

On 3/4/15 at 9:28 a.m., another surveyor confirmed Resident #7's oxygen concentrator

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flow meter was set between the one liter mark and the two liter mark.

On 3/4/15 at 11:00 a.m., the administrator and director of nursing were made aware of the above findings.

The oxygen concentrator manufacturer's instructions documented, "NOTE: To properly read the flow meter, locate the prescribed flow rate line on the flow meter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter per minute) line prescribed..."

The facility policy titled, "RESPIRATORY: OXYGEN ADMINISTRATION" documented in part, "PREPARATION OF EQUIPMENT: 3. For oxygen concentrator, plug in power cord, turn unit on and set flow meter to correct flow rate - extracts oxygen from room air..."

No further information was presented prior to exit.

*"A nasal cannula is a two-pronged tube attached to the oxygen device for delivering oxygen through the nose." This information was obtained from the website: http://www.thoracic.org/patients/patient-resources/resources/oxygen-therapy.pdf

**The oxygen saturation level is a measurement of how much oxygen your blood is carrying. This information was obtained from the website: http://www.thoracic.org/patients/patient-resources/resources/pulse-oximetry.pdf

2. Resident # 13 was observed on separate occasions during the survey with the oxygen flow

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| F 328 | Continued From page 48<br>rate set at 1 1/2 liters per minute and at 3 liters a minute; the physicians order was for oxygen at 2 liters a minute continuously.<br>Resident #13 was admitted to the facility on 6/11/2014. Diagnoses included but were not limited to: hemiplegia (paralysis) of the left leg, hypertension (high blood pressure), kidney failure, depression, gallbladder inflammation, TIA (mini-stroke), anemia, CHF (heart disease) and dementia.<br>The most recent MDS (minimum data set), a quarterly assessment, with an assessment reference date (ARD) of 1/22/2015 coded the resident with a BIMS (Brief Interview for Mental Status) score of 15 on a scale of 0-15, 15 indicating the resident was cognitively intact. Resident was coded as requiring extensive assistance with all ADLs (activities of daily living) except for feeding which was coded as requiring supervision.<br>Resident #13 was observed on 3/3/2015 at 2:37 pm. The resident was in bed with O2 (oxygen) on via a nasal cannula. The oxygen flow rate on the oxygen concentrator was observed set at 1 ½ liters/minute. A second observation was made at 5:30 pm. The resident was sitting up in bed eating dinner wearing the nasal cannula, the oxygen flow rate was observed set at of 2 liters/minute.<br>Resident #13 was observed on 3/4/2015 at 7:55 am., in bed eating breakfast with O2 on via a nasal cannula the O2 flow rate on the oxygen concentrator was observed set at 3 liters/minute.<br>The physician's orders dated 2/25/2015 documented, "6/12/2014 Oxygen at 2L (liters)/MIN (minute) via nasal cannula continuously."<br>Review of the Medication Administration Record for March 2015 documented, "Oxygen at 2L/MIN via nasal cannula continuously." O2 at 2 | F 328 | | |

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| F 328 | Continued From page 49<br>liters/minute was documented by the facility staff each shift on the dates of the observation.<br>An interview was conducted on 3/4/2015 at 10:10 am with RN (Registered Nurse) #5. RN #5 was asked how she read the O2 flow rate, she stated, "You get at eye level and make sure the ball is in the middle of the line." When asked to check Resident 13's oxygen flow rate, RN #5 stated, "A little under 3 liters, let me go check his order." RN #5 was then asked who was responsible for assessing the oxygen flow rates for residents. She stated, "The nurse, when she goes in to assess the patient, checks the O2 sat (oxygen saturation), notify the MD (medical doctor) if the O2 (oxygen) is above the ordered O2." RN #5 stated, "I have not assessed the patient this morning."<br>An interview was conducted on 3/4/2015 at 10:15 am with RN #4. She was asked about the process of checking oxygen for residents and reading the flow meter. RN #4 stated, "We check the sat (oxygen saturation) during assessment." When RN #4 was asked how to read the flow meter, she stated, "Kneel down on your knees to check flow." When asked where the flow meter ball should be, RN #4 stated, "The O2 ball should be in the middle of the line."<br>An interview was conducted on 3/4/2015 at 10:30 am with the ADON (Assistant Director of Nursing), regarding the proper way to read an oxygen flow meter and when the oxygen flow rate should be checked. She stated, "Get on eye level to check." The ADON stated, "Nurses are to check it when they come on and when they go into the room." The ADON was then asked where the flow meter ball should be. She stated, "In the middle of the line."<br>The oxygen concentrator manufacturer's instructions documented, "NOTE: To properly | F 328 | | |

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| F 328 | Continued From page 50<br>read the flow meter, locate the prescribed flow rate line on the flow meter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter per minute) line prescribed..."<br>According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122. "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."<br>The administrator and DON (Director of Nursing) were made aware of these findings on 3/4/2015 at 11:10 am.<br>3. Resident #10 was admitted to the facility on 7/23/09 and again on 5/31/14 with diagnoses that included anemia (low iron), heart failure, hypertension (high blood pressure), diabetes mellitus (high blood sugar), hyperlipidemia (high cholesterol), anxiety, depression, schizophrenia, asthma (disease that affects breathing), altered mental status, kidney disease, obesity and pain.<br><br>The most recent MDS (minimum dada set), a quarterly assessment with an ARD (assessment reference date) of 12/15/14 coded Resident #10 as being cognitively intact for daily decision making. Resident # 10 was coded as requiring extensive assistance of one staff member for all of her activities of daily living. Section "O" of the MDS entitled "Special Treatments, Procedures, and Programs" coded Resident #10 as requiring "Oxygen Therapy." | F 328 | | |

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| F 328 | Continued From page 51<br>Observations on 3/3/15 at approximately 3:00 p.m. revealed Resident #10 sitting up in her bed receiving oxygen by a *nasal cannula which was connected to an oxygen concentrator (a medical device used to deliver oxygen to those who require it.). Further observation of Resident #10's oxygen concentrator revealed the flow meter on the concentrator set between 1.5 (one and a half) and 2 (two) liters per minute.<br><br>Observations on 3/3/15 at approximately 5:25 p.m. revealed Resident #10 lying in her bed, watching television receiving oxygen by a nasal cannula which was connected to an oxygen concentrator. Further observation of Resident #10's oxygen concentrator revealed the flow meter on the concentrator set between 1.5 (one and a half) and 2 (two) liters per minute.<br><br>Observations on 3/4/15 at approximately 8:50 a.m. revealed Resident #10 sitting up in her bed, eating breakfast independently, receiving oxygen by a nasal cannula which was connected to an oxygen concentrator. Further observation of Resident #10's oxygen concentrator revealed the flow meter on the concentrator set between 1.5 (one and a half) and 2 (two) liters per minute.<br><br>Observations on 3/4/15 at approximately 2:10 p.m. revealed Resident #10 lying in her bed, awake with the head of the bed slightly elevated receiving oxygen by a nasal cannula which was connected to an oxygen concentrator. Further observation of Resident #10's oxygen concentrator revealed the flow meter on the concentrator set between 1.5 (one and a half) and 2 (two) liters per minute.<br><br>An observation on 3/4/15 at approximately 2:15 | F 328 | | |

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| F 328 | Continued From page 52<br>p.m. with LPN (licensed practical nurse) #6 revealed Resident #10 sitting up in her bed receiving oxygen by a nasal cannula which was connected to an oxygen concentrator. LPN #6 was asked to read the oxygen flow rate on Resident #10's oxygen concentrator. LPN #6 stated, "It looks like it's at one and a half liters/minute." When asked how to read the flow rate on the oxygen concentrator, LPN #6 stated, "The middle of the ball should be on the line that indicates how much oxygen." LPN #6 then reviewed the physician order and stated. "It should be at two liter per minute." When asked if there is documentation of Resident #10's oxygen being checked, LPN #6 stated, "We don't document it if the oxygen is continuous."<br><br>The "Physician's Order Sheet" dated 2/1/15-2/28/15 and signed by the physician on 1/29/15 documented, "05/31/14 Oxygen at 2 (two) L/MIN (liters per minute) via (by) nasal cannula continuous to keep sats [(saturation) The percentage of how much oxygen your blood is carrying] at 90% or above."<br><br>A review of Resident #10's MAR (medication administration record) dated March 2015 did not document evidence of Resident #10's oxygen being checked.<br><br>Resident #10's comprehensive care plan with a target date of 3/26/2015 was reviewed. Under the heading "Focus" it documented, "Risk for cardiac complications, need for monitoring related to hypertension, CHF (congestive heart failure), hyperlipidemia." Under "Goal" it documented, "Will exhibit no acute cardiac distress such as c/o (complaint of) chest pain, cyanosis (a condition in which the lips, fingers, and toes appear blue), | F 328 | | |

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SOB (shortness of breath), etc (etcetera) ... " Under "Interventions" it documented, "Administer oxygen as ordered. Date initiated 08/05/2009."

An interview was conducted with RN (registered nurse) #3, nurse supervisor on 3/4/15 at approximately 2:30 p.m. When asked what the procedure was for ensuring a resident's oxygen flow rate was correct RN #3 stated, "It should be checked at the beginning of each shift and anytime during the shift." When asked how to read the flow rate on the oxygen concentrator, RN #3 stated, "The line of the flow rate should pass through the middle of the ball." RN #3 was asked to read oxygen flow rate on Resident #10's oxygen concentrator. RN #3 stated, "It's at one and a half liters/minute."

The (Name of Company) user manual for the oxygen concentrator documented, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter per minute) line prescribed."

Nursing Interventions and Clinical Skills, 2nd edition, Elkin, Perry and Potter 2000, page 936. "Oxygen is a drug and is administered and monitored with the same care as any other medication."

The Administrator and Director of Nursing were made aware of these findings on 3/4/15 at approximately 4:30 p.m.

No further information was obtained prior to exit.

*A nasal cannula consists of two small plastic tubes, or prongs, that are placed in both nostrils.

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| F 328 | Continued From page 54<br>Taken from<br>http://www.nhlbi.nih.gov/health/health-topics/topics/oxt/howdoes. | F 328 | | |
| F 387<br>SS=D | 483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT<br><br>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.<br><br>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.<br><br>This REQUIREMENT is not met as evidenced by:<br>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 28 residents in the survey sample, Resident #1.<br><br>The physician (or nurse practitioner) did not examine Resident #1 from 10/29/14 until 1/17/15, a period of 80 days.<br><br>The findings include:<br><br>Resident #1 was admitted to the facility on 4/25/08 with diagnoses that included but were not limited to: intracranial (brain) injury, osteomyelitis (bone infection)* and dysphagia (swallowing disorder) **. Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/15/14, coded the resident's cognition as being severely | F 387 | F387<br><br>It is the intended practice of this facility to ensure that residents are seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.<br><br>Criteria 1<br>Physician for Resident #1was reeducated on timely physician visits.<br><br>Criteria 2<br>All residents have the potential to be affected.<br><br>All physicians and Medical Record staff will be reeducated on timely physician visits.<br><br>Criteria 3<br>All physicians and Medical Record staff will be reeducated on timely physician visits.<br><br>Criteria 4<br>Administrator/designee will randomly audit physician visits weekly x4 weeks and monthly x2 months and report to QAA committee for review and recommendations.<br><br>Criteria 5<br>The facilities alleged date of compliance is April 18, 2015. | 04/18/15 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| MANORCARE HEALTH SERVICES-STRATFORD HALL REVISED | 2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |

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| F 387 | Continued From page 55<br>impaired.<br><br>Review of Resident #1's clinical record revealed the physician (or nurse practitioner) did not examine Resident #1 from 10/29/14 until 1/17/15, a period of 80 days.<br><br>On 3/4/15 at 11:20 a.m., an interview was conducted with OSM (other staff member) #4, the employee responsible for tracking physicians' visits. OSM #4 stated residents are supposed to be seen by the physician on admission, every 30 days for 90 days, then if skilled (receiving Medicare services), every 30 days but if long term care, every 60 days. OSM #4 stated there was a ten day grace period per the regulation but in regards to Resident #1's visits, the physician was running late from 10/29/14 through 1/17/15.<br><br>On 3/4/15 at 12:35 p.m., the administrator and director of nursing were made aware of the above findings.<br><br>The facility policy titled, "MONITORING PHYSICIAN VISITS AND DOCUMENTATION" documented in part, "PURPOSE: To ensure physician visits are timely and documented in the clinical record. GUIDELINES: 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..."<br><br>No further information was presented prior to exit.<br>*This information was obtained from the website: http://www.nlm.nih.gov/medlineplus/ency/article/000437.htm | F 387 | | |

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| F 387 | Continued From page 56<br><br>** This information was obtained from the website:<br>http://www.nlm.nih.gov/medlineplus/swallowingdisorders.html | F 387 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can | F 431 | F431<br><br>It is the intended practice of this facility to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drugs records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>It is also the intended practice of this facility to label all drugs and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>It is also the intended practice of this facility to store all drugs and biologicals in accordance with State and Federal laws, in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys and provide separately locked, permanently affixed compartments for storage of controlled drugs in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missed dose can be readily detected. | 04/18/15 |

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| F 431 | Continued From page 57<br>be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to secure medications on 1 of 5 nursing units (the 600 unit).<br><br>LPN (licensed practical nurse) #2 left medications on top of the medication cart and the cart unlocked and unsupervised during the medication pass observation on the 600 unit.<br><br>The findings include:<br><br>On 3/3/15 at 5:05 p.m., the surveyor arrived on the 600 nursing unit for the medication administration observation. A medication cart was observed in the hallway, against the wall, the drawers/front side facing out towards the open hallway. The cart was observed unlocked. An inverted drinking cup was on top of the cart. Under this cup were the following medications: *hydrocodone 7.5 mg, (milligrams) (a narcotic pain medication), *potassium 20 meq (milliequivalents) (used for potassium replacement), and *hydralazine 25 mg. (used to treat high blood pressure) (the medications were for Resident #20).<br><br>On 3/3/15 at 5:07 p.m., a staff member (social services) walked by the cart and pushed in a drawer that was slightly cracked open.<br><br>On 3/3/15 at 5:08 p.m., Resident #27 went past | F 431 | **Criteria 1**<br>Incident report completed for Resident #19. MD notified with no new orders.<br><br>Resident #20 received her medications as ordered.<br><br>LPN#2 educated on not leaving medications unsupervised and on not leaving medication cart unlocked during medication administration to ensure the safety of Residents #27 and #28.<br><br>**Criteria 2**<br>All residents have the potential to be affected.<br><br>Nurses have been reeducated on not leaving medications unsupervised and on not leaving medication cart unlocked while unattended.<br><br>**Criteria 3**<br>LPN #2 on not leaving medications unsupervised and on not leaving medication cart unlocked while unattended.<br><br>Reeducate the nursing staff on not leaving medications unsupervised and on not leaving medication cart unlocked while unattended. | |

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| F 431 | Continued From page 58<br>the cart in her wheelchair.<br><br>On 3/3/15 at 5:10 p.m., LPN #2 (Licensed Practical Nurse #2) returned to the cart.<br><br>At this time (5:11 p.m.), LPN #2 moved the cart down the hall to the room of Resident #19, turning the cart so the drawers faced towards the resident's room, in the doorway of the room. LPN #2 was observed pulling the lock on the cart out all the way with his hand, and did not attempt to use a key to unlock the cart, indicating the cart was not locked. LPN #2 was observed preparing medications for another resident (Resident #19). The inverted drinking cup containing medications remained on top of the cart. He picked the cup up, and in doing so, clearly revealed that a medication cup containing pills was under the drinking cup. When asked what resident the medications were for, he stated, "(name of Resident #20)." At this time, he prepared the following medications for Resident #19:<br>*Neurontin 300 mg (used to treat neuropathy),<br>*Nexium 40 mg (used to treat GERD),<br>*Oxycodone 10 mg (narcotic pain medication), and **Miralax (a heaping cap full) (used to treat constipation). He then searched the cart for *Tylenol (used to treat pain) and was not able to locate any for the resident. He then placed an inverted drinking up over the cup of medications, (now having 2 inverted drinking cups covering medications on top of the cart - for Resident #20 and #19), and left the cart unsupervised and unlocked to obtain the Tylenol from the stat box. This was approximately 5:20 p.m. At approximately 5:23 p.m., LPN #2 returned to the cart and administered the prepared medications to Resident #19. | F 431 | <u>Criteria 4</u><br>ADNS/designee will randomly audit medication administration weekly x4 weeks and monthly x2 months and report to QAA committee for review and recommendations.<br><br><u>Criteria 5</u><br>The facilities alleged date of compliance is April 18, 2015. | |

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| F 431 | Continued From page 59<br>After administering medications to Resident #19, LPN #2 was observed placing the medications for Resident #20 inside the medication cart. LPN #2 then moved the cart down to the room for Resident #28 (approximately 5:26 p.m.). LPN #2 placed the medication cart in front of the room for Resident #28, the cart was positioned in the doorway facing into the resident's room. He then prepared the following medications for Resident #28: *aspirin 81 mg (used to prevent blood clots), *Tylenol 650 mg, and ***Thera M multivitamin (for vitamin deficiency). He was observed searching the medication cart for *caltrate with Vitamin D (used to replace calcium and vitamin D) to administer the resident but was unable to locate it. He then left the cart again, to search the medication room for caltrate at approximately 5:30 p.m.. LPN #2 left the cart unlocked and unsupervised. He returned to the cart at approximately 5:36 p.m.<br><br>On 3/4/15 at 3:08 p.m., an interview was conducted with LPN #2. He stated he was nervous about being watched and should not have left meds (medications) on top of the cart, unattended or the cart unlocked. When it was discussed that the cart was unlocked and medications were unsupervised on top of it when the surveyor initially approached the cart, and LPN #2 was not present, he made no comment.<br><br>A review of the facility policy "Medication Administration: Medication Pass" documented, ".....lock medication cart when not in direct view of nurse administering medication..." A review of the facility policy "Medication and Treatment Administration Guidelines" documented, "...Medications and biologicals are securely stored in a locked cabinet, cart or medication | F 431 | | |

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| F 431 | Continued From page 60 | F 431 | | |

room, accessible only to licensed nursing staff and maintained under a lock system when not actively utilized and attended to by nursing staff for medication administration...."

On 3/4/15 at 3:41 p.m., the Director of Nursing and Assistant Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.

Resident #20 was admitted to the facility on 2/15/08 with the diagnoses of but not limited to leg amputation, high blood pressure, osteoporosis, and coronary artery disease. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 2/22/15. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring limited assistance for dressing and supervision for transfers, eating, and hygiene.

Resident #27 was admitted to the facility to 10/19/14 with the diagnoses of but not limited to diabetes, high blood pressure, schizophrenia, depression, and deep vein thrombosis. The most recent MDS coded Resident #27 as cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing, dressing, and bed mobility; limited assistance for transfers out of bed; and supervision for eating and hygiene.

Resident #19 was admitted to the facility on 8/25/14 with the diagnoses of but not limited to paraplegia, chronic obstructive pulmonary disease, high blood pressure, and a pressure sore. The most recent MDS was an annual assessment with an ARD of 2/8/15. The resident

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| F 431 | Continued From page 61 | F 431 | | |

was coded as cognitively intact in ability to make daily life decisions; and was coded as requiring extensive assistance for bathing, hygiene, dressing, and transfers; and limited assistance for eating.

Resident #28 was admitted to the facility on 12/18/13 with the diagnoses of but not limited to high blood pressure, arthritis, thromboembolus, and deep vein thrombosis. The most recent MDS was an annual assessment with an ARD of 12/27/14. The resident was coded as severely cognitively impaired in ability to make daily life decisions; and was coded as requiring total assistance for transfers out of bed; extensive assistance for bed mobility, dressing, and hygiene; and supervision for eating.

According to "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 703. "Make sure that all medications are in locked containers in a room (e.g., medication room) or are under constant surveillance."

According to information obtained from Fundamentals of Nursing: Concepts, Process, and Practice, 4th ed. St Louis: Mosby-Year Book, Inc., page 376, by Potter, Patricia A., and Anne Griffin Perry: "Medications of any sort should not be left unattended, and patients should be observed taking the medication."

According to Fundamentals of Nursing, 6th edition, 2001: Patricia A. Potter and Anne Griffen Perry; Mosby, Inc., page 828, "Guidelines for Safe Narcotic Administration and Control: Store all narcotics in a locked, secure cabinet or container."

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

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FORM APPROVED
OMB NO. 0938-0391

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| F 431 | Continued From page 62<br><br>*Information obtained from Nurse's Drug Guide 2009, Prentice Hall, pages 9, 222, 593, 698, 752, 755, 1152, and 1259<br><br>**Information obtained from http://www.nlm.nih.gov/medlineplus/druginfo/meds/a603032.html<br><br>***Information obtained from http://www.pharmacyhealth.net/d/thera-m-vitamins-8274.htm | F 431 | | |
| F 514<br>SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 28 residents in the survey sample, Residents # 6. Resident # 6's clinical record contained a | F 514 | **F514**<br>It is the intended practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>It is also the intended practice of this facility to ensure that the clinical record contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. | 04/18/15 |

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| F 514 | Continued From page 63<br>document with another resident's name.<br><br>The findings include:<br><br>Resident # 6 was admitted to the facility on 6/12/09 and readmitted on 1/7/13 with diagnoses that included but were not limited to: Alzheimer's disease, diabetes, atrial fibrillation, depression, macular degeneration, anxiety, gastroesophageal reflux disease, chronic obstructive pulmonary disease, and osteoarthrosis.<br><br>Resident # 6's most recent MDS (minimum data set) was an annual assessment, with an ARD (assessment reference date) of 1/16/15. The Resident was coded as being usually understood by others and as sometimes understanding others. The resident was cognitively impaired, scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.<br><br>During a clinical record review another resident's laboratory report was observed in Resident # 6's record.<br><br>During an interview on 3/4/15 at 10:05 a.m. with LPN (licensed practical nurse) # 4 this finding was confirmed. When LPN # 4 was asked who does the filing of laboratory reports LPN # 4 stated that it varies. When the reports are received the nurse faxes a copy to the physician and then files a copy in the resident's chart.<br><br>During an interview on 3/4/15 at 10:10 a.m. with ASM (administrative staff member) # 2, the director of nurses, this finding was revealed. A request was made for the facility policy at this time. | F 514 | **Criteria 1**<br>Resident #6 clinical record was corrected and lab was placed into correct resident's clinical record.<br><br>**Criteria 2**<br>All residents have the potential to be affected.<br><br>Review all lab sections of all residents to ensure complete and accurate clinical records.<br><br>**Criteria 3**<br>Nursing and medical record staff reeducation on need to check resident's charts to ensure correct information is placed in correct resident records.<br><br>**Criteria 4**<br>ADNS/designee will randomly audit resident clinical records to ensure proper labs are on proper chart weekly x4 weeks and monthly x2 months and report to QAA committee for review and recommendations.<br><br>**Criteria 5**<br>The facilities alleged date of compliance is April 18, 2015. | |

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| F 514 | Continued From page 64<br>On 3/4/15 at 10:50 a.m. a copy of the facility policy was presented by OSM (other staff member) # 4, medical records staff.<br><br>During an interview on 3/4/15 at 11:00 a.m. with ASM # 1, the administrator, this finding of the misfiled laboratory report was revealed.<br><br>The facility's policy, "REQUIREMENTS AND GUIDELINES FOR CLINICAL RECORD CONTENT: A clinical record is compiled as a confidential medical legal document containing sufficient data to identify the patient, justify diagnosis and treatment, document results and reflect the condition of the patient throughout the stay in the center from admission to discharge. A complete record contains an accurate and functional representation of the actual experience of the patient in the center and reflects an interdisciplinary approach to assessment, care planning and care delivery. Review of clinical record documentation is an important aspect of the quality assessment and assurance process."<br><br>No further information was provided by the end of the survey.<br><br>Potter-Perry Fundamentals of Nursing, 6th Edition, page 477 reads: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice." | F 514 | | |

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| MANORCARE HEALTH SERVICES-STRATFORD HALL REVISED | 2125 HILLIARD ROAD<br>RICHMOND, VA 23228 |

| (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 |
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| F 514 | Continued From page 65<br>According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team." | F 514 | | |