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	495283	A. BUILDING _____ B. WING _____	C 04/28/2016

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MANORCARE HEALTH SERVICES-IMPERIAL	1719 BELLEVUE AVENUE RICHMOND, VA 23227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/26/16 through 4/28/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 128 certified bed facility was 115 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents 1 through 20) and 8 closed record reviews (Residents 21 through 28).	F 000	***"The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein".*** ***Our Allegation of Compliance Date is June 23, 2016.***	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to accommodate a roommate request for two of 28 residents in the survey sample, Resident # 15 and 16. 1. The facility staff failed to act upon a request made by Resident #15 to share a room with another resident in the facility.	F 242	**F 242** **Corrective Action:** On 4/29/16, residents #15 and #16 were given a status update regarding their request to share a room. On 5/19/16, a room change was completed to accommodate the roommate request for residents #15 and #16. In addition, both residents were notified of the room change and shown the new room prior to the move with approval noted. MD and R/P's were notified of the room changes as well.	6/12/16

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: N. Thweatt, Adm. | TITLE | (X6) DATE: 5/24/16

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

* Corrected,

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F 242	Continued From page 1 2. The facility staff failed to act upon a request made by Resident #16 to share a room with another resident in the facility. The findings include: 1. Resident #15 was admitted to the facility on 6/6/15, with a readmission date of 7/5/15, with diagnoses that included but were not limited to: Cervical spine quadriplegia (paralysis), dysphagia (difficulty with swallowing), and hypertension (elevated blood pressure). Resident #15's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/16/16. Resident #15 was coded as a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was cognitively intact. During the group interview held on 4/27/16 at 10:30 a.m. Resident #15 stated that he was not allowed to enter a female's room. Resident #15 further stated that he had been told (by administration) that if he wanted to spend time with a "lady friend" he would have to go to one of the day rooms available in the facility. Resident #15 was asked whether he was in a relationship with a female who lived in the facility. Resident #15 stated that he was in a relationship with (name of Resident #16). Resident #15 stated that together they had asked "them" (administration) to allow them (Resident #15 and Resident #16) to share a room together and that their POAs (power of attorneys) had been notified and were agreeable to them (Resident #15 and Resident #16) living in the same room in the facility. Resident #15 was asked whether or not	F 242	**Other Potential Residents Affected:** 6/12/16 Other residents requesting to share a room together had the potential to be affected. **Systemic Changes:** 6/12/16 4/28/16 was the last day of employment at Manor Care Imperial for OSM #2, the Social Worker. Beginning 4/29/16, audits were completed for residents requesting to share a room. Beginning 4/29/16, inter-disciplinary team members as well as administrative staff were re-educated by the Administrator and/or her designee regarding the importance of accommodating roommate request from residents, providing updates to the residents regarding the status of the request and documenting the efforts to complete such within the patient record.	

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the facility had made any arrangements since the POAs had agreed. Resident #15 stated "they" (administration) had not told him anything, he was still waiting but he felt like he was in prison. Resident #15 stated: "They (administration) do not like us being alone in a room where we are not being monitored. I feel like someone is always watching us." Resident #15 was asked how long ago he had made the request, Resident #15 responded, "It's been a while now, just nothing is happening and we really want to do this."

A review of Resident #15's clinical record, including social worker notes, did not reveal any documentation related to Resident #15's request to cohort with a female resident.

On 4/28/16 at 2:10 p.m. an interview was conducted with OSM (other staff member) #9, the admissions coordinator. OSM #9 was asked to describe her process regarding a room change request. OSM #9 responded, "I go and talk to the residents involved and fill out the paperwork to process the room change request. We usually grant their wish." OSM #9 was asked about a room change request for a male and female who had requested to cohort. OSM #9 responded, "We do not allow a male and female to room together. I have never received a request for a male and female to room together." OSM #9 was asked if she attended any IDT (interdisciplinary team) meetings. OSM #9 responded that she did not.

On 4/28/16 at 2:20 p.m. an interview was conducted with OSM #8, the admissions director. OSM #8 was asked whether or not he had received any room requests for a male and

Monitoring System:

6/12/16

Beginning 5/2/16, a weekly audit of residents requesting to share a room will be completed by the Director of Social Services and/or her designee for compliance with facility protocol/ State and/or Federal regulations.

Audits will be conducted for four weeks and then monthly for two months thereafter.

Identified discrepancies will be addressed accordingly and as appropriate.

Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol.

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female resident who wished to cohort. OSM #8 responded, "I know that there was mention of a room change but no particular requests to accommodate a room change." When asked about room availability OSM #8 responded, "I guess we could make a room available, I do know that their (residents involved) POAs are okay with them cohorting, but we have to get permission from other residents involved in making a room available." OSM #8 was asked if anything had been done, OSM #8 responded that from an admissions standpoint they had not done anything.

On 4/28/16 at approximately 2:30 p.m. an interview was conducted with OSM #2, the social worker. OSM #2 was asked if residents in the facility requested to be roomed together, specifically a male and a female, what was the process. OSM #2 stated, "This is under resident rights, I would go to the IDT meeting and discuss the situation." OSM #2 was asked whether or not there was a policy specific to cohorting in the facility. OSM #2 was unable to state whether or not there was a policy. OSM #2 stated, "We have to be mindful of resident rights. We would involve the POAs, whoever is making the decisions for the residents and then figure out the actions to take." OSM #2 was asked to describe her next steps following a discussion with the POAs. OSM #2 stated that she would discuss it with the rest of the team in the IDT meeting. OSM #2 was asked whether or not she would document the situation in the resident's clinical record. OSM #2 responded that she would usually write a note about the request and the steps taken. OSM #2 was asked specifically about Resident #15 and if he had come to her to request to cohort with a female resident in the facility. OSM #2 stated that

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she was familiar with the request and had taken the request to the IDT meeting and also had spoken with the POAs for both parties and they were agreeable to the situation. OSM #2 was asked how much time had expired since the request by the residents involved had been made and the POAs had agreed. OSM #2 was unable to say how long she had been working on this. OSM #2 was asked where her documentation was located regarding this situation. OSM #2 stated she had not documented in the record, "I wrote in my personal notes and I can look back and see what I have, but I have destroyed most of my notes, today is my last day and I have been putting everything in the burn box." OSM #2 was asked who was now taking the lead on the request made by the residents. OSM #2 stated that the IDT was aware.

On 4/28/16 at approximately 2:40 p.m. an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 was asked if she was aware of two residents in the facility, a male and a female, who had requested to cohort. ASM #1 responded that she was aware and that the situation had been discussed several times in the IDT meetings. ASM #1 was asked where the documentation was that recorded the situation, ASM #1 responded, "The social work section (in the clinical record) should have notes." ASM #1 was made aware that there were no notes in the clinical record. ASM #1 responded that she knew that it had been discussed and that they were "still working on it." A policy was requested regarding room change requests and cohorting.

No further documentation was provided prior to the end of survey.

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2. Resident #16 was admitted to the facility on 12/14/14, with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease), depression, hypercholesterolemia (high levels of cholesterol in the blood), anxiety, hypertension (elevated blood pressure), dementia and dysphagia (difficult swallowing).

Resident #16's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/18/16. Resident #16 was coded as a 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was cognitively intact.

During the group interview held on 4/27/16 at 10:30 a.m. Resident #16 stated that she was not allowed to have a male friend in her room. Resident #16 further stated that she had been told (by administration) that if she wanted to spend time with a "male friend" she would have to go to one of the day rooms available in the facility. Resident #16 was asked whether she was in a relationship with a male who lived in the facility. Resident #16 stated that she was in a relationship with (name of Resident #15). Resident #16 stated that together they had asked "them" (administration) to allow them (Resident #15 and Resident #16) to share a room together and that their POAs (power of attorneys) had been notified and were agreeable to them (Resident #15 and Resident #16) living in the same room in the facility. Resident #16 was asked whether or not the facility had made any arrangements since the POAs had agreed. Resident #16 stated "they" (administration) had

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not told her anything, she was still waiting. Resident #16 was asked how long ago she had made the request, Resident #16 responded, "I don't remember but nothing is happening and we really want to do this."

A review of Resident #16's clinical record, including social worker notes, did not reveal any documentation related to Resident #16's request to share a room with a male resident.

A review of Resident #16's care plan dated 3/29/16 did not reveal any information regarding Resident #16's request to cohort with a male resident in the facility.

On 4/28/16 at 2:10 p.m. an interview was conducted with OSM (other staff member) #9, the admissions coordinator. OSM #9 was asked to describe her process regarding a room change request. OSM #9 responded, "I go and talk to the residents involved and fill out the paperwork to process the room change request. We usually grant their wish." OSM #9 was asked about a room change request for a male and female who had requested to cohort. OSM #9 responded, "We do not allow a male and female to room together. I have never received a request for a male and female to room together." OSM #9 was asked if she attended any IDT (interdisciplinary team) meetings. OSM #9 responded that she did not.

On 4/28/16 at 2:20 p.m. an interview was conducted with OSM #8, the admissions director. OSM #8 was asked whether or not he had received any room requests for a male and female resident who wished to cohort. OSM #8 responded, "I know that there was mention of a

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room change but no particular requests to accommodate a room change." When asked about room availability OSM #8 responded, "I guess we could make a room available, I do know that their (residents involved) POAs are okay with them cohorting, but we have to get permission from other residents involved in making a room available." OSM #8 was asked if anything had been done, OSM #8 responded that from an admissions standpoint they had not done anything.

On 4/28/16 at approximately 2:30 p.m. an interview was conducted with OSM #2, the social worker. OSM #2 was asked if residents in the facility requested to be roomed together, specifically a male and a female, what was the process. OSM #2 stated, "This is under resident rights, I would go to the IDT meeting and discuss the situation." OSM #2 was asked whether or not there was a policy specific to cohorting in the facility. OSM #2 was unable to state whether or not there was a policy. OSM #2 stated, "We have to be mindful of resident rights. We would involve the POAs, whoever is making the decisions for the residents and then figure out the actions to take." OSM #2 was asked to describe her next steps following a discussion with the POAs. OSM #2 stated that she would discuss it with the rest of the team in the IDT meeting. OSM #2 was asked whether or not she would document the situation in the resident's clinical record. OSM #2 responded that she would usually write a note about the request and the steps taken. OSM #2 was asked specifically about Resident #16 and if she had come to her to request to cohort with a male resident in the facility. OSM #2 stated that she was familiar with the request and had taken the request to the IDT meeting and also had

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F 242	Continued From page 8 spoken with the POAs for both parties and they were agreeable to the situation. OSM #2 was asked how much time had expired since the request by the residents involved had been made and the POAs had agreed. OSM #2 was unable to say how long she had been working on this. OSM #2 was asked where her documentation was located regarding this situation. OSM #2 stated she had not documented in the record, "I wrote in my personal notes and I can look back and see what I have, but I have destroyed most of my notes, today is my last day and I have been putting everything in the burn box." OSM #2 was asked who was now taking the lead on the request made by the residents. OSM #2 stated that the IDT was aware. On 4/28/16 at approximately 2:40 p.m. an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 was asked if she was aware of two residents in the facility, a male and a female, who had requested to cohort. ASM #1 responded that she was aware and that the situation had been discussed several times in the IDT meetings. ASM #1 was asked where the documentation was that recorded the situation, ASM #1 responded, "The social work section (in the clinical record) should have notes." ASM #1 was made aware that there were no notes in the clinical record. ASM #1 responded that she knew that it had been discussed and that they were "still working on it." A policy was requested regarding room change requests and cohorting. No further documentation was provided prior to the end of survey.	F 242		
F 247	483.15(e)(2) RIGHT TO NOTICE BEFORE	F 247		

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F 247 SS=D	Continued From page 9 ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to notify a resident prior to a room change for one of 28 residents in the survey sample, Resident #4. The facility social worker failed to provide evidence that Resident #4 was notified of the room change, shown his new room or introduced to his new roommate prior to a move on 11/24/15. The findings include: Resident #4 was admitted to the facility on 5/16/15 with diagnoses including, but not limited to: dementia with behaviors, high blood pressure, benign prostate enlargement, and anemia. On the most recent MDS (minimum data set), a quarterly assessment with ARD (assessment reference date) 2/13/16, Resident #4 was coded as having moderate cognitive impairment for making daily decisions, having scored six out of 15 on the BIMS (brief interview for mental status). A review of the progress notes for Resident #4 revealed the following note dated 11/24/15: "Room change notification from [location of original room] to [location of current room]." Further review revealed the following social	F 247	**F 247** **Corrective Action:** **6/12/16** Due to the room change occurring on 11/24/15, staff met with Resident #4 on 5/19/16 and determined he was adjusting well to the room change and his roommate without any difficulty. **Other Potential Residents Affected:** **6/12/16** Other residents who had a room change within the facility and were not notified of the room change, shown the room or introduced to the roommate prior to the move had the potential to be affected.	

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F 247	Continued From page 10	F 247	**Systemic Changes:**	6/12/16

services note dated 11/25/15: "Late Entry: Patient was moved yesterday due to roommate compatibility. Patient's RP (responsible party) was contacted about the room change and agreeable."

Further review revealed another social services note written by OSM (other staff member) #2, a social worker, and dated 11/25/15: "SS (social services) visited resident in his new room. He stated that he is pleased with room change and voiced no concerns."

A review of Resident #4's comprehensive care plan revealed, in part, the following: "Cognitive loss as evidenced by confusion...Allow adequate time to respond. Do not rush or supply words...Approach/speak in a calm, positive/reassuring manner. Attempt to provide consistent routines/caregivers. Explain each activity/care procedure prior to beginning it."

On 4/28/16 at 1:40 p.m., an attempt was made to interview OSM #2 regarding this room change for Resident #4. When asked the procedure which she followed prior to a resident's room change, she stated: "I would like to get back to you on that." When asked about what kinds of actions by the social worker would be important for a resident prior to a room change, she stated: "I will have to get back to you on that." At this time, OSM #2 was asked to review Resident #4's record regarding the room change on 11/24/15 and to provide any evidence that Resident #4 and the responsible party had been notified prior to the room change and Resident #4 had been given the opportunity to view the new room and meet his new roommate, prior to the move.

Beginning 4/29/16 an audit of resident room changes within the facility was completed to determine if they were notified of the room change, shown the room or introduced to the roommate prior to the move.

Beginning 4/29/16, inter-disciplinary team members as well as administrative staff were re-educated by the Administrator and/or her designee regarding the importance of accommodating roommate request from residents, providing updates to the residents regarding the status of the request and documenting the efforts to complete such within the patient record.

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F 247	Continued From page 11 On 4/28/16 at 2:10 p.m., OSM #2 returned to the surveyor and presented her with the three notes outlined above. She stated: "I don't have anything else to add." On 4/28/16 at 2:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate consultant, were informed of these concerns. They were also informed that the social worker had refused to complete an interview with the surveyor. When asked whose job it was to facilitate internal resident moves and to introduce residents to the new roommates, ASM #1 stated: "The social worker." Policies regarding room changes were requested. No further information was provided prior to exit.	F 247	**Monitoring System:** Beginning 5/2/16, a weekly audit of resident room changes within the facility will be completed by the Director of Social Services or her designee for compliance with facility protocol/state and/or Federal regulations. Audits will be conducted for Four weeks and then monthly for two months thereafter. Identified discrepancies will Be addressed accordingly and As appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol.	6/12/16
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide medically related social services for two of 28 residents in the survey sample, Residents #19 and #4. 1. The social worker failed to invite Resident #19	F 250		

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F 250	Continued From page 12	F 250	**F 250**	

to care plan meetings.

2. The social worker failed to show Resident #4/his responsible party the new room and failed to introduce them to the new roommate prior to a move on 11/24/15.

The findings include:

1. The social worker failed to invite Resident #19 to care plan meetings.

Resident #19 was admitted to the facility on 9/19/11 and readmitted to the facility on 7/30/14. Resident #19's diagnoses included but were not limited to: high blood pressure and major depressive disorder. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/11/16, coded the resident as being cognitively intact, scoring a 15 out of a possible 15 on the brief interview for mental status interview. Resident #19's comprehensive care plan revised on 4/26/16 failed to document information regarding the resident's participation in care plan meetings.

On 4/28/16 at 2:45 p.m., an interview was conducted with Resident #19. The resident was asked if she participates in meetings where staff plans her activities and daily medication and nursing care (care plan meetings). Resident #19 stated her daughter probably attends the meetings and she thought her daughter went to one meeting after the resident had a mastectomy; however, Resident #19 stated she (Resident #19) had never been invited to the meetings. Resident #19 was asked if she would like to attend her care plan meetings. The resident stated, "I

Corrective Action: **6/12/16**

On 5/19/16, resident #19 was educated regarding her right to be invited to care plan meetings. In addition, her current plan of care was reviewed with her.
Due to the room change occurring on 11/24/15, staff met with Resident #4 on 5/19/16 and determined he was adjusting well to the room change and his roommate without any difficulty.

Other Potential Residents Affected: **6/12/16**

Other residents who were not invited to Care Plan meetings and/or had a room change within the facility and was not notified of the room change, shown the new room or introduced to the new roommate had the potential to be affected.

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F 250	Continued From page 13 guess. They probably forgot I am here because I'm so quiet." On 4/28/16 at 3:17 p.m., an interview was conducted with OSM (other staff member) #2 (the social worker). OSM #2 stated she didn't invite residents to care plan meetings. OSM #2 stated the activities department sends residents letters to invite them to the meetings. On 4/28/16 at 4:13 p.m., an interview was conducted with OSM #6 (the interim activities director). OSM #6 stated she didn't know who invited residents to care plan meetings. On 4/28/16 at 4:17 p.m., an interview was conducted with OSM #8 (the administrative assistant). OSM #8 stated she calls residents' family members to arrange care plan meeting appointments but does not talk to residents. On 4/28/16 at 4:19 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. ASM #1 stated the social worker was responsible for inviting residents to care plan meetings. Page 10 from the facility social service manual documented in part, "Social Service Role: Coordinate a process to invite the patient or responsible party to care conferences..." No further information was presented prior to exit. 2. The social worker failed to show Resident #4/his responsible party the new room and failed	F 250	**Systemic Change:** 4/28/16 was the last day of employment at Manor Care Imperial for OSM #2, the Social Worker. Beginning 4/29/16, audits were completed for residents either requesting to share a room and/or experiencing a room change within the facility. Beginning 4/29/16, inter-disciplinary team members as well as administrative staff were re-educated by the Administrator and/or her designee regarding the importance of accommodating roommate request from residents, providing updates to the residents regarding the status of the request and documenting the efforts to complete such within the patient record.	6/12/16

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F 250	Continued From page 14 to introduce them to the new roommate prior to a move on 11/24/15. Resident #4 was admitted to the facility on 5/16/15 with diagnoses including, but not limited to: dementia with behaviors, high blood pressure, benign prostate enlargement, and anemia. The most recent MDS (minimum data set), a quarterly assessment with ARD (assessment reference date) of 5/13/15, coded Resident #4 as having moderate cognitive impairment for making daily decisions, having scored six out of 15 on the BIMS (brief interview for mental status). A review of the progress notes for Resident #4 revealed the following note dated 11/24/15: "Room change notification from [location of original room] to [location of current room]." Further review revealed the following social services note dated 11/25/15: "Late Entry: Patient was moved yesterday due to roommate compatibility. Patient's RP (responsible party) was contacted about the room change and agreeable." Further review revealed another social services note written by OSM (other staff member) #2, a social worker, and dated 11/25/15: "SS (social services) visited resident in his new room. He stated that he is pleased with room change and voiced no concerns." A review of Resident #4's comprehensive care plan revealed, in part, the following: "Cognitive loss as evidenced by confusion...Allow adequate time to respond. Do not rush or supply words...Approach/speak in a calm,	F 250	**Monitoring System:** Beginning 5/2/16, a weekly random audit of 10% the documentation for residents room changes/requests will be conducted by the Director of Social Services and/or her designee for compliance. Audits will be conducted for four weeks and then monthly for two months thereafter. Identified discrepancies will be addressed accordingly and/or as appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol.	6/12/16

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positive/reassuring manner. Attempt to provide consistent routines/caregivers. Explain each activity/care procedure prior to beginning it."

On 4/28/16 at 1:40 p.m., an attempt was made to interview OSM #2 regarding this room change for Resident #4. When asked the procedure which she followed prior to a resident's room change, she stated: "I would like to get back to you on that." When asked about what kinds of actions by the social worker would be important for a resident prior to a room change, she stated: "I will have to get back to you on that." At this time, OSM #2 was asked to review Resident #4's record regarding the room change on 11/24/15 and to provide any evidence that Resident #4 and the responsible party had been notified prior to the room change and Resident #4 had been given the opportunity to view the new room and meet his new roommate, prior to the move.

On 4/28/15 at 2:10 p.m., OSM #2 returned to the surveyor and presented her with the three notes outlined above. She stated: "I don't have anything else to add."

On 4/28/15 at 2:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate consultant, were informed of these concerns. They were also informed that the social worker had refused to complete an interview with the surveyor. When asked whose job it was to facilitate internal resident moves and to introduce residents to the new roommates, ASM #1 stated: "The social worker." Policies regarding room changes were requested.

No further information was provided prior to exit.

Corrective Action: **6/12/16**

On 5/19/16, an activity interview was completed for resident #5. A significant correction for this assessment was not completed as 2 subsequent assessments were completed which accurately reflects the residents status.

On 4/29/16, a modification to a prior assessment for section H for resident #3 was completed to accurately reflect the resident's urinary incontinence status.

For resident #6, a correction to a prior assessment was not completed as a regularly scheduled subsequent assessment was completed on 5/12/16, which accurately reflects the residents pressure ulcer status.

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F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for three of 28 residents in the survey sample, Residents # 5, 3, and 6.

Other Potential Residents Affected: **6/12/16**

Other residents who require Section F of an MDS assessment to be completed had the potential to be affected.

Other residents who require Section H of an MDS assessment to be completed had the potential to be affected.

Other residents who require Section M of an MDS assessment to be completed had the potential to be affected.

Systematic Changes: **6/12/16**

Beginning 5/19/16, an audit of Section F was completed for Activity Interview coding & Activity Preference, Section H - Foley Catheters and Section M – Skin accuracy for current residents who require MDS assessments with discrepancies noted and/or corrected as spplicable and appropriate per RAI guidelines.

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F 278	Continued From page 17 1. The facility staff failed to accurately code Resident # 5's annual MDS (minimum data set) with an ARD (assessment reference date) of 12/14/15 to demonstrate that the Interview for Daily and Activity Preferences had been attempted. 2. The facility staff failed to accurately code Resident #3's urinary continence in her quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/27/15. 3. The facility staff failed to accurately code Resident #6's pressure ulcer on her quarterly MDS assessment with an ARD of 2/11/16. The findings include: 1. The facility staff failed to accurately code Resident #5's annual MDS (minimum data set) with an ARD (assessment reference date) of 12/14/15 to demonstrate that the Interview for Daily and Activity Preferences had been attempted. Resident #5 was admitted to the facility on 5/2/11 with diagnoses that included but were not limited to diabetes, peripheral vascular disease, hypertension, glaucoma, and dementia. Resident #5's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 3/15/16, coded the resident as being moderately impaired cognitively and as having short term and long term memory deficits. In Section B "Hearing, Speech, and Vision" under B0700 "Makes Self Understood" a "2" was entered indicating that.	F 278	Beginning 5/19/16, staff who complete MDS assessments were re-educated by the Regional Case Mix Specialist regarding the importance of completing Section F, Section H and M accurately and per RAI guidelines. **Monitoring System:** **6/12/16** Beginning 5/24/16, a weekly random audit of 10 MDS assessments will be reviewed for accuracy validation by the Administrator and/or her designee for compliance per the RAI guidelines. Audits will be conducted for four weeks and then monthly for two months thereafter. Identified discrepancies will be addressed accordingly and/or as appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol.	

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Resident #5 was "Sometimes understood." Under "B0800: Ability to Understand Others" a "2" was entered indicating that Resident #5 "Sometimes understands." Review of the annual MDS with an ARD of 12/14/15 documented that there was no change in the Resident's cognitive functioning, short term or long term memory and no change in whether the Resident could understand or be understood.

Review of the annual MDS assessment revealed that under Section F: Preferences for Customary Routine and Activities, under F0300. Should Interview for Daily Activity Preferences be Conducted? A "0" was entered. This indicated that the interview with the Resident was not completed. The instruction documents that the Resident interview should be attempted unless the Resident is rarely/never understood.

During an interview on 4/28/16 at 9:45 a.m. with LPN (licensed practical nurse) #5, one of the MDS coordinators, LPN #5 stated that at times the MDS staff does the activity interviews. LPN #5 reviewed the annual MDS and stated that she would check on why the interview was not done with the resident and who should have done it. LPN #5 was then asked what source is used as a reference when filling out the MDS. LPN #5 stated that the RAI (resident assessment instrument) is the reference that is used.

During an interview on 4/28/16 at 11:25 a.m. with LPN #5 and RN (registered nurse) # 5, another MDS coordinator, RN #5 stated that the employee that did the activities interview is no longer at the facility. When asked if the interview with the resident should have been attempted, RN # 5 stated, "Yes, she (resident) should have

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been interviewed for the activities."

During an interview on 4/28/16 at 2:45 p.m. with ASM (Administrative staff member) #1, the administrator, and ASM #2, the director of nurses, this concern was revealed.

No further information was provided prior to exit.

"CMS's RAI MDS 3.0 Manual CH 3: MDS Items [F] May 2011 Page F-1

SECTION F: PREFERENCES FOR CUSTOMARY ROUTINE AND ACTIVITIES

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.
F0300: Should Interview for Daily and Activity Preferences Be Conducted?
Item Rationale
Health-related Quality of Life
· Most residents capable of communicating can answer questions about what they like.
· Obtaining information about preferences directly from the resident, sometimes called "hearing the resident's voice," is the most reliable and accurate way of identifying preferences.
· If a resident cannot communicate, then family

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or significant other who knows the resident well may be able to provide useful information about preferences.

Planning for Care
· Quality of life can be greatly enhanced when care respects the resident's choice regarding anything that is important to the resident.
· Interviews allow the resident's voice to be reflected in the care plan.
· Information about preferences that comes directly from the resident provides specific information for individualized daily care and activity planning.

Steps for Assessment
1. Determine whether or not resident is rarely/never understood and if family/significant other is available. If resident is rarely/never understood and family is not available, skip to item F0800, Staff Assessment of Daily and Activity Preferences.
2. Review Language item (A1100) to determine whether or not the resident needs or wants an interpreter.
· If the resident needs or wants an interpreter, complete the interview with an interpreter.
3. The resident interview should be conducted if the resident can respond:
· Verbally,
· by pointing to their answers on the cue card, OR
· by writing out their answers.

CMS's RAI MDS 3.0 Manual CH 3: MDS Items [F] May 2011 Page F-2
F0300: Should Interview for Daily and Activity Preferences Be Conducted?
Coding Instructions

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Record whether the resident preference interview should be attempted.
· 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).
· 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).

Coding Tips and Special Populations
· If the resident needs an interpreter, every effort should be made to have an interpreter present for the MDS clinical interview. If it is not possible for a needed interpreter to be present on the day of the interview, and a family member or significant other is not available for interview, code F0300 = 0 to indicate interview not attempted, and complete the Staff Assessment of Daily and Activity Preferences (F0800) instead of the interview with the resident (F0400 and F0500)."·
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).
Code 1, yes: if the resident interview should be

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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)..."

2. The facility staff failed to accurately code Resident #3's urinary continence in her quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/27/15.

Resident #3 was admitted to the facility on 1/17/15 with diagnoses that included, but were not limited to: pressure ulcer, obstructive and reflux uropathy (a condition in which the flow of urine is blocked*), anxiety, insomnia (difficulty falling asleep), muscle weakness, anemia, atrial fibrillation (an abnormal heart rhythm), hypertension (elevated blood pressure) and Hepatitis A (a disease causing inflammation of the liver**).
Resident # 3's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/24/16, coded Resident #3 as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating that Resident #3 was cognitively intact.

Section H, Bladder and Bowel, for Resident #3's MDS quarterly assessment with an ARD of 10/27/15 coded Resident #3 in sub-section H0100, Appliances, as having an indwelling catheter. In sub-section H0300, Urinary continence, Resident #3 was coded as "3. Always incontinent".

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The RAI (resident assessment instrument) manual defines incontinence as; "the involuntary loss of urine." A Code 3 in sub-section H0300 indicates that the resident is "always incontinent."

A review of Resident #3's care plan dated 1/17/15 revealed, in part, the following documentation: "Focus: Use of indwelling urinary catheter needed due to wound healing, urinary retention."

An interview was conducted on 4/28/16 at 9:40 a.m. with LPN (licensed practical nurse) #5, the MDS coordinator. LPN #5 was asked to describe her process for completing the MDS for each resident. LPN #5 responded, "I follow the RAI manual to do assessments on residents. I also interview residents, assess, ask nursing staff and look at medical records." LPN #5 was shown the assessment in Section H for Resident #3 and was asked whether or not it was coded correctly. LPN #5 stated she would get back with this surveyor about the coding.

On 4/28/16 at 4:10 p.m. RN (registered nurse) #3 approached this surveyor and stated, "The coding was incorrect for (name of Resident #3's) continence. It (sub-section H0300) should have been coded as a 9 "not-rated." because the resident (Resident #3) did have an indwelling catheter at the time the MDS was completed. I have already corrected this and submitted the correction." RN #3 was asked what she used as a reference to complete the MDS, RN #3 stated that she used the RAI manual.

On 4/28/16 at approximately 4:30 p.m. ASM (administrative staff member) #1, the administrator, was made aware of the above

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

*This information was obtained from the following website:
https://www.nlm.nih.gov/medlineplus/ency/article/000507.htm
** This information was obtained from the following website:
ttps://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3aproject=medlineplus&v%3asources=medlineplus-bundle&query=hepatitis%20A&

3. The facility staff failed to accurately code Resident #6's pressure ulcer on her quarterly MDS assessment with an ARD of 2/11/16.

Resident #6 was admitted to the facility on 2/15/12 with a readmission on 7/22/15 with diagnoses that included, but not limited to: CVA (cerebral vascular accident - stroke), dysphagia (difficulty swallowing), muscle weakness, pressure ulcer to right hip, depressive disorder, diabetes, and heart disease.

Resident # 6's most recent MDS (minimum data set), was a quarterly assessment with an ARD (assessment reference date) of 2/11/16. Resident #6 was coded as scoring an 8 out of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns; indicating that Resident #6 was cognitively moderately impaired.

Section M, Skin Condition, on Resident #6's quarterly MDS assessment with an ARD of 2/11/16 coded Resident #6 in sub-section M0300,

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Current Number of Unhealed Pressure Ulcers, as having "One (1) unhealed Stage 2* pressure ulcer present on admission.

A review of Resident #6's clinical record revealed, in part, the following wound round notes performed by the IDT (interdisciplinary team) during the 14 day look back period for Resident #6's MDS with the ARD of 2/11/16:
"1/26/16 Note Text: Wound rounds performed by IDT. 1. Stage III (3) to right hip."
"2/2/16 Note Text: Wound rounds performed by IDT. 1. Stage III (3) to right hip."
"2/9/16 Note Text: Wound rounds performed by IDT. 1. Stage III to right hip."

A review of Resident #6's care plan dated 8/29/15 documented, in part, the following; "Focus. Resolved: pressure ulcer right hip. Resolved Date 3/8/16."

An interview was conducted on 4/28/16 at 9:40 a.m. with LPN (licensed practical nurse) #5, the MDS coordinator. LPN #5 was asked to describe her process for completing the MDS for each resident. LPN #5 responded, "I follow the RAI manual to do assessments on residents. I also interview residents, assess, ask nursing staff and look at medical records." LPN #5 was shown Resident #6's MDS with an ARD of 2/11/16 and asked why the pressure ulcer was described as a Stage 2. LPN #5 responded: "I use the description in the note and compare to the description provided in the RAI manual to determine the stage of the wound." LPN #5 was asked if she had looked at the wound. LPN #5 responded that she had not. LPN #5 was asked if she attended wound rounds with the IDT. LPN #5 stated that she did not. LPN #5 was asked if

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she was aware that the wound team notes documented Resident #6 as having a Stage III pressure ulcer to her right hip and not a Stage 2. LPN #5 stated that she used the description of the wound that was documented by the IDT to determine the stage of the wound. LPN #5 was asked if she had discussed the wound with the wound nurse, LPN #5 stated that she had, had some conversations. LPN #5 was asked whether or not she was able to downgrade a wound, LPN #5 stated that she used the RAI manual for her instructions.

On 4/28/16 at 10:30 a.m. an interview was conducted with RN (registered nurse) #2, the wound nurse. RN #2 was asked who was responsible for staging pressure ulcers in the facility. RN #2 responded, "If a new admission we use the hospital staging and make notes based on how the wound looks but cannot downstage, we can say it's a healing stage (provide level) wound." RN #2 was asked what type of wound Resident #6 had. RN #2 responded, "She has a healing Stage III wound." RN #2 was asked whether or not the MDS coordinator attended wound rounds, RN #2 stated that she did not. RN #2 was asked whether or not the MDS coordinator was able to downstage the pressure ulcer, RN #2 stated that she could not.

On 4/28/16 at approximately 12 noon, LPN #5 provided this surveyor with a copy of the section of the RAI manual that she used to complete Section M of the MDS. LPN #5 pointed out the definition of the Stage 2 Pressure Ulcer used in the RAI manual. LPN #5 was asked whether or not she had assessed the wound, LPN #5 stated she had not. LPN #5 was asked how she could

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determine the stage of Resident #6's pressure ulcer without an assessment, and when the wound round notes documented the wound as a Stage III. LPN #5 responded, "I used the description provided by the wound nurse as to the color and status of the wound to determine it was a lower stage."

The following instructions for coding a pressure ulcer are provided in the RAI manual:

"Steps for completing M0300A-G
Step 1: Determine Deepest Anatomical Stage
For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.
1. Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved.
2. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see Step 2 below). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item."

On 4/28/16 at approximately 4:00 p.m. ASM (administrative staff member) #1, the administrator, was made aware of these findings. No further information was provided prior to the end of the survey.

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F 278	Continued From page 28 * (1) Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009 This information was obtained from the website:<http://www.npuap.org.pr2.htm>. (2) This information was obtained from the website:<http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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. This REQUIREMENT is not met as evidenced by:	F 280	**F 280** **Corrective Action:** **6/12/16** On 5/19/16, resident #19 was educated regarding her right to be invited to care plan meetings. In addition, the current plan of care was reviewed with her. On 5/19/16, the care plans For residents #18 and #19 Were updated to reflect evidence of a resident altercation with another resident. In addition, interventions to protect the residents from further altercations with other residents were included as well.	

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F 280	Continued From page 29	F 280	**Other Potential Residents Affected:**	**6/12/16**

Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to invite one of 28 residents (Resident #19) to participate in care plan meetings and failed to review and revise the care plan for two of 28 residents, Residents #18 and #19.

1. The facility staff failed to invite Resident #19 to care plan meetings.

2. The facility staff failed to update Resident #18's care plan after an altercation with another resident on 4/15/16.

3. The facility staff failed to update Resident #19's care plan after an altercation with another resident on 4/15/16.

The findings include:

1. The facility staff failed to invite Resident #19 to care plan meetings.

Resident #19 was admitted to the facility on 9/19/11 and readmitted to the facility on 7/30/14. Resident #19's diagnoses included but were not limited to: high blood pressure and major depressive disorder. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/11/16, coded the resident as being cognitively intact, scoring 15 out of a possible 15 on the brief interview for mental status interview. Resident #19's comprehensive care plan revised on 4/26/16 failed to document information regarding the resident's participation in care plan meetings.

On 4/28/16 at 2:45 p.m., an interview was

Other residents that were not invited to care plan meetings and/or the care plan was not updated to reflect an incidence of resident to resident altercation had the potential to be affected.

Systemic Change: **6/12/16**

Beginning 5/19/16, audits were completed to determine compliance with inviting residents to participate in the care planning process.

In addition, audits were completed for updates to the care plan to accurately reflect incidence of resident to resident altercations.

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F 280	Continued From page 30 conducted with Resident #19. The resident was asked if she participates in meetings where staff plans her activities and daily medication and nursing care (care plan meetings). Resident #19 stated her daughter probably attends the meetings and she thought her daughter went to one meeting after the resident had a mastectomy; however, Resident #19 stated she (Resident #19) had never been invited to the meetings. Resident #19 was asked if she would like to attend her care plan meetings. The resident stated, "I guess. They probably forgot I am here because I'm so quiet." On 4/28/16 at 3:17 p.m., an interview was conducted with OSM (other staff member) #2 (the social worker). OSM #2 stated she didn't invite residents to care plan meetings. OSM #2 stated the activities department sends residents letters to invite them to the meetings. On 4/28/16 at 4:13 p.m., an interview was conducted with OSM #6 (the interim activities director). OSM #6 stated she didn't know who invited residents to care plan meetings. On 4/28/16 at 4:17 p.m., an interview was conducted with OSM #8 (the administrative assistant). OSM #8 stated she calls residents' family members to arrange care plan meeting appointments but does not talk to residents. On 4/28/16 at 4:19 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. ASM #1 stated the social worker was responsible for inviting residents to care plan meetings.	F 280	Beginning 5/19/16, inter-disciplinary team members were re-educated by the Administrator and/or her designee regarding the importance of inviting residents to participate in care plan meetings, updating the care plan to accurately reflect patient status such as resident to resident altercations and the proper documentation of such per RAI guidelines. **Monitoring System:** Beginning 5/24/16, a weekly Random audit of 10% of the Care plans will be reviewed by the Director of Social Services and/or her designee for evidence of residents being invited and/or participating in the care planning process and compliance per the RAI guidelines.	6/12/16

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F 280	Continued From page 31 Page 10 from the facility social service manual documented in part, "Social Service Role: Coordinate a process to invite the patient or responsible party to care conferences..." No further information was presented prior to exit. 2. The facility staff failed to update Resident #18's care plan after an altercation with another resident on 4/15/16. Resident #18 was admitted to the facility on 3/28/14 with diagnoses including, but not limited to: peripheral vascular disease, esophageal reflux, high blood pressure and dementia with behaviors. The most recent MDS (minimum data set) assessment, a quarterly assessment with ARD (assessment reference date) 3/8/16, coded Resident #18 as having mild cognitive impairment for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status). A review of the nurse's notes for Resident #18 revealed, in part, the following note dated 4/15/16 at 4:25 p.m.: "Male resident approach (sic) female resident sitting in hallway. Was involved in altercation. Pain assessment was done. No c/o (complaints of) pain or discomfort voiced. Body audit was done. Negative except for dressing to right foot." A review of the facility's FRI (facility reported incident) investigation for this date revealed that the facility thoroughly investigated this incident, assessed the female resident, and followed up with her responsible party and physician.	F 280	In addition, a weekly random audit of 10% of the care plans for residents involved in resident to resident altercations will be reviewed by the ADNS and/or her designee for evidence of the care plan being updated to accurately reflect such and compliance per the RAI guidelines.	

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A review of the comprehensive care plan for Resident #18 dated 3/17/15 and updated 2/23/16 revealed no evidence of this incident or of interventions to protect Resident #18 from further altercations with other residents.

On 4/28/16 at 1:40 p.m., OSM (other staff member) #2, the social worker, was interviewed regarding care plan updates after resident-to-resident altercations which did not result in injury. She stated that she is notified by nursing, and that together, they discuss and evaluate what needs to be done. She stated: "We talk about what happened and where to go from here." She stated that the staff would need to be alert to any special needs a resident might have. When asked where those needs would be documented, she stated: "If I felt it was needed, I would have nursing document it." When asked if Resident #18's care plan should have been updated following this incident, she did not answer.

On 4/28/16 at 2:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate consultant, were informed of these concerns. ASM #2 stated: "We updated [the male resident]'s care plan. That should have taken care of it."

No further information 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

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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. "

3. The facility staff failed to update Resident #19's care plan after an altercation with another resident on 4/15/16.

Resident #19 was admitted to the facility on 9/19/11 with diagnoses including but not limited to: major depression, history of a stroke and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment dated 4/11/16, Resident #19 was coded as having no cognitive impairment, having scored 15 out of 15 on the BIMS (brief interview for mental status).

A review of the nurse's notes for Resident #19 revealed, in part, the following note dated 4/15/16 at 4:25 p.m.: "Male resident approached female resident while she was in her room. Was involved in altercation. Pain assessment was done and no complaints of pain or discomfort noted. Body assessment attempted but was to head and arms due to resident's refusal of full body assessment. Was negative."

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A review of the facility's FRI (facility reported incident) investigation for this date revealed that the facility thoroughly investigated this incident, assessed the female resident, and followed up with her responsible party and physician.

On 4/28/16 at approximately 1:48 p.m., Resident #19 was asked about this incident. She stated that she was not harmed, and that the facility staff had re-assessed her for concerns on several occasions since the incident occurred.

A review of the comprehensive care plan for Resident #19 dated 9/30/11 and updated 4/21/15 revealed no evidence of this incident or of interventions to protect Resident #19 from further altercations with other residents.

On 4/28/16 at 1:40 p.m., OSM (other staff member) #2, the social worker, was interviewed regarding care plan updates after resident-to-resident altercations which did not result in injury. She stated that she is notified by nursing, and that together, they discuss and evaluate what needs to be done. She stated: "We talk about what happened and where to go from here." She stated that the staff would need to be alert to any special needs a resident might have. When asked where those needs would be documented, she stated: "If I felt it was needed, I would have nursing document it." When asked if Resident #19's care plan should have been updated following this incident, she did not answer.

On 4/28/16 at 2:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate consultant, were informed of these concerns.

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F 280	Continued From page 35 ASM #2 stated: "We updated [the male resident]'s care plan. That should have taken care of it." No further information was provided prior to exit.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for two of 28 residents in the survey sample, Resident #10 and 7. 1. The facility staff failed to develop an initial care plan for pressure ulcer prevention for Resident #10. 2. The facility staff signed off a treatment for compression stockings* as being done, when the staff had actually not applied the stockings to Resident #7. The findings include: 1. The facility staff failed to develop an initial care plan for pressure ulcer prevention for Resident #10. Resident #10 was admitted to the facility on	F 281	**F 281** **Corrective Action:** On 4/25/16, the care plan for resident #10 was updated to reflect at risk status and pressure ulcer prevention interventions. On 4/27/16, the Licensed Practical nurse assigned to resident #7 was immediately relieved of her duties and placed on suspension pending further investigation. R/P and MD were notified of the compression stockings for resident #7 not being applied per physician orders. No new orders were given.	**6/12/16**

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-IMPERIAL	1719 BELLEVUE AVENUE RICHMOND, VA 23227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 36	F 281	**Other Potential Residents Affected:**	6/12/16

4/22/16 with diagnoses including, but not limited to: dementia with behaviors, peripheral vascular disease and high blood pressure. The admission nursing assessment dated 4/22/16, assessed Resident #10 as having moderate cognitive impairment for making daily decisions, having scored six out of 15 on the BIMS (brief interview for mental status). She was assessed to be dependent on facility staff for bed mobility. She was assessed as not having any pressure ulcers.

A review of the admission nursing assessment for Resident #10 dated 4/22/16 revealed that she scored 13 out of 23, indicating a moderate risk of developing a pressure ulcer.

A review of the nurses' notes revealed a note written on 4/25/16 5:33 p.m. by RN (registered nurse) #2, the wound nurse. The note documented, in part: "Resident noted to have stage II (two) present to sacrum. Area measuring 2.0 X 5.0 X 0 cm (centimeters). Wound bed beefy red in color, surrounding skin macerated (rough), no drainage, no odor, cleaned with saline and covered with Duoderm thin^, dressing to be changed q 2 days (every two days). [Name of physician] in facility and is aware of area, RP (responsible party) in facility and made aware."

A review of the physician's orders revealed the following order written and signed by the physician on 4/25/16: "Cleanse sacrum with normal saline; pat dry, cover with Duoderm thin q 2 days (every two days)."

On 4/27/16 at 1:50 p.m., RN #2 was observed as she provided wound care to Resident #10. Resident #10's sacral wound measured 3.5 X 6.4 X 0 cms. The wound bed was beefy red, and

Other residents not care planned for pressure ulcer prevention, not having compression stockings applied and/or documented per physician orders and at the time of service had the potential to be affected.

Systemic Changes: **6/12/16**

On 4/27/16, a comparison audit of patients scoring at risk (using the Braden scale) for developing a pressure ulcer and pressure ulcer prevention interventions on the care plan was completed with no discrepancies noted.

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F 281	Continued From page 37 there was no odor or drainage from the wound. There were no concerns related to the wound care/treatment of the pressure ulcer. On 4/27/16 at 3:00 p.m., RN #2 was interviewed regarding the admission nursing assessment for Resident #10's pressure ulcer risk. She stated that she had completed Resident #10's admission skin assessment, but had not done the pressure ulcer risk scale. She stated that another facility nurse had completed the risk scale (this nurse was not available for interview prior to exit). She stated that Resident #10 did not have any pressure areas when she was admitted on 4/22/16. When asked about Resident #10's pressure ulcer risk as identified on the admission nursing assessment, she stated: "She scored a 13 on the Braden (a scale used to identify residents' risk for developing a pressure ulcer). She was definitely at risk." When asked if a care plan and interventions should have been put into place on 4/22/16 to prevent a pressure ulcer from developing, she stated: "Absolutely." When asked what kinds of interventions should have been put into place, she stated: "Specialty mattress, wheelchair cushions, maybe even supplements." A review of the initial care plan for Resident #10, revealed nothing regarding pressure ulcer prevention. On 4/27/16 at 5:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate consultant, were informed of these concerns. A policy regarding the development of care plans was requested.	F 281	Beginning 4/27/16, the wound nurse as well as licensed nursing staff were re-educated by the ADNS and/or her designee Regarding the importance of completing a care plan that reflects a patients current at risk status for developing a pressure ulcer and interventions for prevention. On 5/3/16, the LPN in question Received was returned from Suspension and received a final written warning disciplinary action for failure to comply with a physician's order and document administration/application of those efforts at the time of service only. In addition, the LPN was re-educated by the ADNS regarding the importance of adhering to physician orders and documenting administration/application at the time of service only. Beginning 4/27/16, a compliance audit inspection of patients with orders for compression stockings to be applied was completed with no discrepancies noted.	

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F 281	Continued From page 38 A review of the facility policy entitled "Skin Practice Guide" revealed, in part, the following: "Admission Skin Evaluation: If the patient does not have a skin alteration, but has risk factors that put the patient at risk for skin breakdown, an initial plan of care is initiated. The initial plan of care includes identifying patient specific risk factors for the development of pressure ulcers and identifying and evaluating risk factors that can be removed or modified upon admission. " No further information was provided prior to exit. *The NPUAP defines a pressure ulcer as a "...localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction." Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009. This information is taken from the website <http://www.npuap.org.pr2.htm>. #Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). This information is	F 281	Beginning 4/27/16, licensed nursing staff were re-educated by the ADNS and/or her designee regarding the importance of adhering to a physician's order and documenting administration/ application of those efforts at the time of service only. **Monitoring System:** Beginning, 5/2/16, a weekly random comparison audit of 10% of patients scoring at risk (using the Braden scale) for developing a pressure ulcer and pressure ulcer prevention interventions on the care plan will be completed by the ADNS and/or her designee for compliance. Beginning 5/2/16, a weekly random audit of 10% of residents with orders for the application of compression stockings will be completed by the ADNS and/or her designee for compliance with physician orders and documentation at the time at the time of service only.	

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F 281	Continued From page 39 taken from the website <http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ > ^DuoDERM Extra Thin dressing is a hydrocolloid dressing indicated for the management of lightly exuding wounds. It combines a unique ConvaTec hydrocolloid formulation that distinguishes it from other hydrocolloid dressings and a vapor-permeable outer film to provide an occlusive moist environment. This information is taken from the distributor's website http://www.medline.com/jump/product/x/Z05-PF4 2109. 2. The facility staff signed off a treatment for compression stockings* as being done, when the staff had actually not applied the stockings to Resident #7. Resident #7 was admitted to the facility on 6/18/15 with diagnoses including, but not limited to: infection of the bone, depression, dementia and arthritis. The most recent MDS (minimum data set) assessment, a quarterly assessment with ARD (assessment reference date) 3/13/16, coded Resident #7 as having moderate cognitive impairment for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status). She was coded as being completely dependent on facility staff for bed mobility, personal hygiene, and bathing. She was coded as requiring the extensive assistance of staff for transfers from bed to chair, dressing and toileting. On 4/27/16 at 8:15 a.m., 11:05 a.m., 1:05 p.m.,	F 281	Audits will be conducted for four weeks and then monthly for two months thereafter. Identified discrepancies will be addressed accordingly and as appropriate.	

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F 281	Continued From page 40	F 281		

and 2:10 p.m., Resident #7 was observed lying in her bed with the head of her bed elevated. She did not have compressions stockings applied to her legs during any of these observations.

A review of Resident #7's clinical record revealed the following order, written 8/4/15 and most recently signed on 4/8/16: "Compression stockings: knee-high: Size 3X. Apply at 9am and remove at 9pm."

A review of the April 2016 TAR (treatment administration record) revealed LPN (licensed practical nurse) #7's initials in the block for 4/27/16 at 9:00 a.m.

On 4/27/16 at 2:35 p.m., LPN #7 accompanied this surveyor to Resident #7's bedside. LPN #7 showed the surveyor Resident #7's legs, which now had compression stockings applied. LPN #7 was asked when the stockings had been applied. LPN #7 did not reply. LPN #7 was asked if she had applied the stockings in the last 30 minutes. LPN #7 shook her head affirmatively. LPN #7 was asked if she had signed off the compression stockings as being applied at 9:00 a.m., and she stated that she had. She stated: "I usually put them on. I don't really leave it to anyone else. I just didn't get to it today." When asked if she should have signed the compression stockings off as being applied when they had not been applied to the resident, she stated: "No. I shouldn't. I know better than that."

A review of the comprehensive care plan for Resident #7 dated 6/26/15 and updated 4/18/16 revealed, in part, the following: "Compression stockings as ordered."

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F 281	Continued From page 41 On 4/27/16 at 5:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate consultant, were informed of these concerns. ASM #2 was asked which professional standard of practice the facility followed regarding documentation of treatments. She stated that the facility followed their own policy as the professional standard. A review of the facility policy entitled "Medication and Treatment Administration Guidelines" revealed, in part, the following: "Medication and treatments administered are documented immediately following administration or per state specific standards." No further information was provided prior to exit. *"TED hose are compression stockings. You wear compression stockings to improve blood flow in your legs. Compression stockings gently squeeze your legs to move blood up your legs. This helps prevent leg swelling and, to a lesser extent, blood clots." This information was taken from the website http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000597.htm According to Lippincott Williams and Wilkins in Fundamentals of Nursing 2007 page 53, "Don't alter a client's record, this is a criminal offense. Never add information at a later date without indicating that you did so. Never document anything that you did not do."	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 42 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services to promote the highest level of well-being for one of 28 residents in the survey sample, Resident #7. The facility staff failed to apply compression stockings* as ordered by the physician for Resident #7. The findings include: Resident #7 was admitted to the facility on 6/18/15 with diagnoses including, but not limited to: infection of the bone, depression, dementia and arthritis. The most recent MDS (minimum data set) assessment, a quarterly assessment with ARD (assessment reference date) 3/13/16, coded Resident #7 as having moderate cognitive impairment for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status). She was coded as being completely dependent on facility staff for bed mobility, personal hygiene, and bathing. She was coded as requiring the extensive assistance of staff for transfers from bed to chair, dressing	F 309	**F 309** **6/12/16** **Corrective Action:** On 4/27/16, the Licensed Practical Nurse assigned to resident #7 was immediately relieved of her duties and placed on suspension pending further investigation. Both R/P and MD were notified of the compression stockings for resident #7 not being applied per physician orders. No new orders were given. **Other Potential Residents Affected:** **6/12/16** Other residents who did not have compression stockings applied and documented per physician orders and at the time of service only had the potential to be affected.	

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F 309	Continued From page 43 and toileting. On 4/27/16 at 8:15 a.m., 11:05 a.m., 1:05 p.m., and 2:10 p.m., Resident #7 was observed lying in her bed with the head of her bed elevated. She did not have compressions stockings applied to her legs at any of these observations. A review of Resident #7's clinical record revealed the following order, written 8/4/15 and most recently signed on 4/8/16: "Compression stockings: knee-high: Size 3X. Apply at 9am and remove at 9pm." A review of the April 2016 TAR (treatment administration record) revealed LPN (licensed practical nurse) #7's initials in block for 4/27/16 at 9:00 a.m. On 4/27/16 at 2:35 p.m., LPN #7 accompanied this surveyor to Resident #7's bedside. LPN #7 showed the surveyor Resident #7's legs, which now had compression stockings applied. LPN #7 was asked when the stockings had been applied. LPN #7 did not reply. LPN #7 was asked if she had applied the stockings in the last 30 minutes. LPN #7 shook her head affirmatively. LPN #7 was asked if she had signed off the compression stockings as being applied at 9:00 a.m., and she stated that she had. She stated: "I usually put them on. I don't really leave it to anyone else. I just didn't get to it today." When asked if she should have signed the compression stockings off as being applied when they had not been applied to the resident, she stated: "No. I shouldn't. I know better than that." A review of the comprehensive care plan for Resident #7 dated 6/26/15 and updated 4/18/16	F 309	**Systemic Changes:** On 5/3/16, the LPN in question received a final written warning disciplinary action for failure to comply with a physician's order and document administration/ application of those efforts at the time of service only. In addition, the LPN was re-educated by the ADNS regarding the importance of adhering to physician orders and documenting administration/application at the time of service only. Beginning 4/27/16, a compliance audit inspection of patients with orders for compression stockings to be applied was completed with no discrepancies noted. Beginning 4/27/16, licensed nursing staff were re-educated by the ADNS and/or her designee regarding the importance of adhering to a physician's order and documenting administration/ application of those efforts at the time of service only.	6/12/16

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F 309	Continued From page 44 revealed, in part, the following: "Compression stockings as ordered." On 4/27/16 at 5:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate consultant, were informed of these concerns. A review of the facility policy entitled "Anti-Embolism Stockings - Elastic Stockings" revealed, in part, the following: "Apply stocking...Verify stockings are worn in bed and during ambulation to provide continuous therapy." No further information was provided prior to exit. *"TED hose are compression stockings. You wear compression stockings to improve blood flow in your legs. Compression stockings gently squeeze your legs to move blood up your legs. This helps prevent leg swelling and, to a lesser extent, blood clots." This information was taken from the website http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000597.htm According to Fundamentals of Nursing, 6th edition, Perry and Potter 2005, page 1451-1453, "Elastic stockings (sometimes called thromboembolic device hose) (TED) also aid in maintaining external pressure on the muscles of the lower extremities and thus may promote venous return....The skill of applying TED hose can be performed by assistive personnel. The nurse is responsible for assessing circulation to the lower extremities....Record date and time of stocking application and stocking length and size in nurse's notes....Record condition of skin and circulatory assessment."	F 309	**Monitoring System:** Beginning 5/2/16, a weekly random audit of 10 residents with orders for the application of compression stockings will be completed by the ADNS and/or her designee for compliance with physician orders and documentation at the time at the time of service only. Audits will be conducted for four weeks and then monthly for two months thereafter. Identified discrepancies will be Addressed accordingly and as Appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol.	6/12/16

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314	**F 314**	

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility failed to provide care and services in a manner to prevent the development of a pressure ulcer* for one of 28 residents in the survey sample, Resident #10.

On admission to the facility on 4/22/16, Resident #10 was identified as being at risk for the development of a pressure ulcer. The facility staff failed to implement interventions to prevent the development of a pressure ulcer. Resident #10 was identified as having a Stage 2 pressure ulcer# on 4/25/16.

The findings include:

Resident #10 was admitted to the facility on 4/22/16 with diagnoses including, but not limited to: dementia with behaviors, peripheral vascular disease and high blood pressure. The admission nursing assessment dated 4/22/16, assessed Resident #10 as having moderate cognitive impairment for making daily decisions, having

Corrective Action: **6/12/16**

On 4/25/16, the MD for resident #10 was notified with orders obtained for interventions to prevent and treat the development of a pressure ulcer. The R/P was notified as well.

In addition, the care plan for was updated to reflect at risk status and interventions for pressure ulcer prevention.

Other Potential Residents Affected. **6/12/16**

Other residents who did not have interventions implemented to their plan of care for pressure ulcer prevention had the potential to be affected.

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F 314	Continued From page 46 scored six out of 15 on the BIMS (brief interview for mental status). She was assessed to be dependent on facility staff for bed mobility. She was assessed as not having any pressure ulcers. A review of the admission nursing assessment for Resident #10 dated 4/22/16 revealed that she scored a 13 out of 23, indicating a moderate risk of developing a pressure ulcer. A review of the nurses' notes revealed a note written on 4/25/16 5:33 p.m. by RN (registered nurse) #2, the wound nurse. The note documented, in part: "Resident noted to have stage II (two) present to sacrum. Area measuring 2.0 X 5.0 X 0 cm (centimeters). Wound bed beefy red in color, surrounding skin macerated (rough), no drainage, no odor, cleaned with saline and covered with Duoderm thin^, dressing to be changed q 2 days (every two days). [Name of physician] in facility and is aware of area, RP (responsible party) in facility and made aware." A review of the physician's orders revealed the following order written and signed by the physician on 4/25/16: "Cleanse sacrum with normal saline; pat dry, cover with Duoderm thin q 2 days (every two days)." On 4/27/16 at 1:50 p.m., RN #2 was observed as she provided wound care to Resident #10. Resident #10's sacral wound measured 3.5 X 6.4 X 0 cms. The wound bed was beefy red, and there was no odor or drainage from the wound. There were no concerns related to the wound care/treatment of the pressure ulcer. On 4/27/16 at 3:00 p.m., RN #2 was interviewed regarding the admission nursing assessment for	F 314	**Systemic Changes:** On 4/27/16, a comparison audit of patients scoring at risk (using the Braden scale) for developing a pressure ulcer and pressure ulcer prevention interventions on the care plan was completed with no discrepancies noted. Beginning 4/27/16, the wound nurse as well as licensed nursing staff were re-educated by the ADNS and/or her designee Regarding the importance of completing a care plan that reflects a patients current at risk status for developing a pressure ulcer and interventions for prevention.	6/12/16

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F 314	Continued From page 47	F 314	**Monitoring System:**	6/12/16

Resident #10's pressure ulcer risk. She stated that she had completed Resident #10's admission skin assessment, but had not done the pressure ulcer risk scale. She stated that another facility nurse had completed the risk scale (this nurse was not available for interview prior to exit). She stated that Resident #10 did not have any pressure areas when she was admitted on 4/22/16. When asked about Resident #10's pressure ulcer risk as identified on the admission nursing assessment, she stated: "She scored a 13 on the Braden (a scale used to identify residents' risk for developing a pressure ulcer). She was definitely at risk." When asked if a care plan and interventions should have been put into place on 4/22/16 to prevent a pressure ulcer from developing, she stated: "Absolutely." When asked what kinds of interventions should have been put into place, she stated: "Specialty mattress, wheelchair cushions, maybe even supplements."

A review of the initial care plan for Resident #10 revealed nothing regarding pressure ulcer prevention.

On 4/27/16 at 5:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate consultant, were informed of these concerns.

A review of the facility policy entitled "Skin Practice Guide" revealed, in part, the following: "Admission Skin Evaluation: If the patient does not have a skin alteration, but has risk factors that put the patient at risk for skin breakdown, and initial plan of care is initiated. The initial plan of care includes identifying patient specific risk factors for the development of pressure ulcers

Beginning, 5/2/16, a weekly random comparison audit of 10% of patients scoring at risk (using the Braden scale) for developing a pressure ulcer and pressure ulcer prevention interventions on the care plan will be completed by the ADNS and/or her designee for compliance.

Audits will be conducted for four weeks and then monthly for two months thereafter.

Identified discrepancies will be addressed accordingly and as appropriate.

Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol.

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and identifying and evaluating risk factors that can be removed or modified upon admission. "

No further information was provided prior to exit.

*The NPUAP defines a pressure ulcer as a "...localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction." Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009. This information is taken from the website <http://www.npuap.org.pr2.htm>.

#Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). This information is taken from the website <http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/>

^DuoDERM Extra Thin dressing is a hydrocolloid dressing indicated for the management of lightly exuding wounds. It combines a unique ConvaTec

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F 314	Continued From page 49 hydrocolloid formulation that distinguishes it from other hydrocolloid dressings and a vapor-permeable outer film to provide an occlusive moist environment. This information is taken from the distributor's website http://www.medline.com/jump/product/x/Z05-PF4 2109.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as	F 356	**F 356** **Corrective Action:** **6/12/16** On 4/28/16, the nursing staff posting report was updated to include the actual staff hours. **Other Potential Residents Affected:** **6/12/16** Residents residing in the facility who could not review the nursing staff posting report for actual hours had the potential to be affected. **Systemic Changes:** **6/12/16** On 4/28/16, an audit of the nursing staff posting sheets for actual hours listed was completed.	

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F 356	Continued From page 50 required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure accurate nurse staffing was posted for two days of the survey process. The findings include: Observation was made on 4/27/16 at 4:20 p.m. of the "Staff Posting Report". This report was on a table close to the front door of the facility. Review of this report revealed no documentation of the "Actual Hours" worked for the 07:00 AM - 03:00 PM shift or the 03:00 PM - 11:00 PM shift. A copy of this report was requested of ASM (administrative Staff member) #2, the director of nurses. At this time a copy of the facility policy was requested. Also, at this time a request was made to speak to the staff responsible for filling out this report. During an interview on 4/28/16 at approximately 12:30 p.m. with ASM (administrative staff member) #2, the director of nursing, ASM #2 stated that there is no policy for staff posting. A request was again made to speak to the staffing coordinator. During an interview on 4/28/16 at 12:45 p.m. with ASM #1, the administrator, and ASM # 2, the director of nursing, this concern was again visited. ASM #1 stated that there was no facility policy for staff posting. During an interview on 4/28/16 at 4:03 p.m. with	F 356	On 4/28/16, the Staffing Coordinator, ADNS, Administrator, Business Office Manager/Payroll Coordinator and Director of Human Resources were in-serviced by the Regional Nurse Consultant regarding the federal requirement to update the nursing staff posting sheet daily and by shift to include actual staffing hours. **Monitoring System:** Beginning, 5/2/16, a weekly random audit of the nursing staff posting sheets for inclusion of actual hours will be completed by the Administrator and/or her designee for compliance. Audits will be conducted for four weeks and then monthly for two months thereafter. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol.	6/12/16

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F 356	Continued From page 51 OSM (other staff member) #1, business office assistant and staffing coordinator, the staffing reports for 4/27/16 and 4/28/16 were reviewed. The lack of documentation for "Actual Hours" worked was reviewed. OSM #1 stated, "I don't do anything with the actual hours. I don't do anything on this sheet, but I put it into the computer, all the information for actual hours is in the computer system. I have a "Daily Deployment Sheet" and that has the actual hours worked on it but I do not post that sheet." At this time a copy of the "Staff Posting Report" for 4/28/16 (posted near the front door) was requested. This sheet as the one for 4/27/16 also lacked any "Actual Hours" for the 07:00 AM - 03:00 PM shift or the 03:00 PM - 11:00 PM shift. During an interview on 4/28/16 at 4:07 p.m. with ASM #1, the administrator, ASM #1 stated that she understood that the actual hours are not documented on the sheet. ASM #1 further stated that the (name of the facility) was working on a plan to ensure that this will be remedied. No further information was provided prior to exit.	F 356		
F 385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.	F 385	**F 385** **Corrective Action:** **6/12/16** On 4/29/16 , the MD was notified and an order was obtained to schedule a follow-up appointment with the dermatologist for resident #13. A follow-up appointment For 5/31/16, was obtained for a dermatologist appointment for resident #13. The R/P was notified as well.	

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F 385	Continued From page 52	F 385	**Other Potential Residents Affected:** Other residents who did not have physician orders for follow up appointments to the dermatologist had the potential to be affected. Systemic Changes: On 4/29/16, an audit of consultation reports/paperwork for patients returning from appointments for follow-up recommendation requests was completed with no discrepancies noted. Beginning 4/29/16, licensed nursing Staff were re-educated regarding the importance of reviewing consultation reports/paperwork when a patient returns from an appointment for follow-up recommendation requests.	6/12/16

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and review of facility documentation the facility staff failed to ensure supervision of medical care by the physician for one of 28 residents in the survey sample, (Resident #13).

The physician documented Resident #13 was to have a follow up appointment with the (name) of dermatologist in a progress note dated 10/28/15. The physician failed to write an order for the follow up dermatology appointment. As of 4/28/16, Resident #13 had not seen the dermatologist.

The findings include:

Resident #13 was admitted to the facility on 1/20/15 with diagnoses that included, but were not limited to; CVA (cerebral vascular accident - stroke), atrial fibrillation (an abnormal rhythm of the heart), dementia, dysphagia (difficulty swallowing) and high blood pressure.

Resident #13's most recent comprehensive MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 1/27/16. Resident #13 was coded as a six (6) out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was severely impaired with cognition.

A review of Resident #13's clinical record revealed, in part, a Physician's Progress Note dated 10/28/15 which documented, in part, the

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F 385	Continued From page 53 following: "4. F/U (follow up) (abbreviation for with) (name of physician) - Dermatology. (Name of physician) skin cancer surgeon (telephone number)." A review of the physician orders did not reveal an order for a dermatology appointment. A review of the nurses' notes did not reveal that a time had been set for a dermatology appointment. On 4/28/16 at 12:40 p.m. ASM (administrative staff member) #2, the director of nursing, was interviewed. ASM #2 was asked whether or not there was any evidence that Resident #13 had been scheduled for a dermatology appointment. ASM #2 responded that she could not find any evidence that the appointment had been made. ASM #2 was asked whether or not Resident #13 had seen the dermatologist since 10/28/15, ASM #2 stated she had not. ASM #2 provided the facility policy titled "New Orders for Non-Controlled Substances." This policy did not provide information regarding physician orders for consults. No further information was provided prior to the end of the survey.	F 385	**Monitoring System:** Beginning, 5/2/16, a weekly random comparison audit of 10% of the physician consultant reports/paperwork and scheduled follow up appointments will be completed by the ADNS and/or her designee for compliance. Audits will be conducted for four weeks and then monthly for two months thereafter. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol.	6/12/16
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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	F 431	**F 431** **Corrective Action:** On 4/28/16, the updated vial of Aplisol PPD was immediately discarded.	6/12/16

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F 431	Continued From page 54 controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to label medication in a safe manner in one of two medication rooms, the unit one medication room. The facility staff failed to label an open date on one vial of Aplisol PPD (purified protein derivative) solution (a medication used in the	F 431	**Other Potential Residents Affected:** Residents residing within the facility with physician orders for an Aplisol injection to be given had the potential to affected. Systemic Changes: On 4/28/16, an inspection audit of both unit nurses station medication rooms was completed with no discrepancies noted. Beginning 5/2/16, licensed nursing staff were re-educated regarding the importance of labeling Aplisol PPD vials with an open date when opened.	6/12/16 6/12/16

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F 431	Continued From page 55 diagnosis of tuberculosis [lung infection]) (1) in the unit one medication room. Per manufacturer's instructions, the medication must be discarded 30 days after being opened. The findings include: On 4/28/16 at 9:15 a.m., observation of the unit one medication room was conducted. One vial of PPD solution was observed open and approximately one third full in the medication room refrigerator. No open date was documented on the vial or the box that contained the vial. The manufacturer's box that contained the vial documented, "once entered, vial should be discarded after 30 days." At this time, an interview was conducted with RN (registered nurse) #1 regarding the labeling and storage of medications. RN #1 stated the vial should have been labeled with an open date once opened. RN #1 confirmed no open date was documented on the vial or the box that contained the vial. RN #1 stated the vial would be discarded. The manufacturer's instructions documented, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..." On 4/28/16 at 9:57 a.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above finding. On 4/28/16 at 2:15 p.m., ASM #1 (the administrator) was made aware of the above finding. The facility document titled, "Medication and Treatment Administration Guidelines"	F 431	Monitoring System: Beginning 5/2/16, a weekly random inspection audit of both unit nurses station medication rooms for unlabeled Aplisol PPD vials will be conducted by ADNS and/or her designee for compliance. Audits will be conducted for four weeks and then monthly for two months thereafter. Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol.	6/12/16

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F 431	Continued From page 56 documented in part, "Medication Storage and Security: Medications are stored in accordance with standards of practice (i.e., separate internals from externals; stored at proper temperature; stored in medication only areas..." No further information was presented prior to exit. (1) This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1e91a67c-1694-4523-9548-58f7a8871134	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate record for two of 28 residents in the survey sample, Resident #15 and 16.	F 514	**F 514** **Corrective Action:** On4/28/16, a late entry was entered in the Social services section of the medical records for residents #15 and #16 regarding their request to cohort and the process taken to accommodate their request. On 4/29/16, resident #15 and #16 were updated by the Administrator regarding the status of their request.	**6/12/16**

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F 514	Continued From page 57 1. The facility staff failed to document a request made by Resident #15 to cohort with a female resident and to document the process taken to accommodate Resident #15's request. 2. The facility staff failed to document a request made by Resident #16 to cohort with a male resident and to document the process taken to accommodate Resident #16's request. The findings include: 1. The facility staff failed to document a request made by Resident #15 to cohort with a female resident and to document the process taken to accommodate Resident #15's request. Resident #15 was admitted to the facility on 6/6/15, with a readmission date of 7/5/15, with diagnoses that included but were not limited to: Cervical spine quadriplegia (paralysis), dysphagia (difficulty with swallowing), and hypertension (elevated blood pressure). Resident #15's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/16/16. Resident #15 was coded as a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was cognitively intact. During the group interview held on 4/27/16 at 10:30 a.m. Resident #15 stated that he was not allowed to enter a female's room. Resident #15 further stated that he had been told (by administration) that if he wanted to spend time	F 514	**Other Potential Residents Affected:** Other residents requesting to share a room together had the potential to be affected. **Systemic Changes:** Beginning 4/29/16, audits were completed for residents requesting to share a room. Beginning 4/29/16, inter-disciplinary team members as well as administrative staff were re-educated by the Administrator and/or her designee regarding the importance of accommodating roommate request from residents, providing updates to the residents regarding the status of the request and documenting the efforts to complete such within the patient record.	6/12/16 6/12/16

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	495283	A. BUILDING _____ B. WING _____	C 04/28/2016

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F 514	Continued From page 58	F 514	**Monitoring System:**	6/12/16

with a "lady friend" he would have to go to one of the day rooms available in the facility. Resident #15 was asked whether he was in a relationship with a female who lived in the facility. Resident #15 stated that he was in a relationship with (name of Resident #16). Resident #15 stated that together they had asked "them" (administration) to allow them (Resident #15 and Resident #16) to share a room together and that their POAs (power of attorneys) had been notified and were agreeable to them (Resident #15 and Resident #16) living in the same room in the facility. Resident #15 was asked whether or not the facility had made any arrangements since the POAs had agreed. Resident #15 stated "they" (administration) had not told him anything, he was still waiting but he felt like he was in prison. Resident #15 stated: "They (administration) do not like us being alone in a room where we are not being monitored. I feel like someone is always watching us." Resident #15 was asked how long ago he had made the request, Resident #15 responded, "It's been a while now, just nothing is happening and we really want to do this."

A review of Resident #15's clinical record, including social worker notes, did not reveal any documentation related to Resident #15's request to share a room with a female resident.

A review of Resident #15's care plan dated 7/5/15 did not reveal any information regarding Resident #15's request to cohort with a female resident in the facility.

On 4/28/16 at approximately 2:30 p.m. an interview was conducted with OSM #2, the social worker. OSM #2 was asked if residents in the

Beginning 5/2/16, a weekly audit of residents requesting to share a room will be completed by the Director of Social Services and/or her designee for compliance with facility protocol/ State and/or Federal regulations.

Audits will be conducted for four weeks and then monthly for two months thereafter.

Identified discrepancies will be addressed accordingly and as appropriate.

Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol.

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facility requested to be roomed together, specifically a male and a female, what was the process. OSM #2 stated, "This is under resident rights, I would go to the IDT meeting and discuss the situation." OSM #2 was asked whether or not there was a policy specific to cohorting in the facility. OSM #2 was unable to state whether or not there was a policy. OSM #2 stated, "We have to be mindful of resident rights. We would involve the POAs, whoever is making the decisions for the residents and then figure out the actions to take." OSM #2 was asked to describe her next steps following a discussion with the POAs. OSM #2 stated that she would discuss it with the rest of the team in the IDT meeting. OSM #2 was asked whether or not she would document the situation in the resident's clinical record. OSM #2 responded that she would usually write a note about the request and the steps taken. OSM #2 was asked specifically about Resident #15 and if he had come to her to request to cohort with a female resident in the facility. OSM #2 stated that she was familiar with the request and had taken the request to the IDT meeting and also had spoken with the POAs for both parties and they were agreeable to the situation. OSM #2 was asked how much time had expired since the request by the residents involved had been made and the POAs had agreed. OSM #2 was unable to say how long she had been working on this. OSM #2 was asked where her documentation was located regarding this situation. OSM #2 stated she had not documented in the record, "I wrote in my personal notes and I can look back and see what I have, but I have destroyed most of my notes, today is my last day and I have been putting everything in the burn box." OSM #2 was asked who was now taking the lead on the request made by the residents. OSM #2 stated

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that the IDT was aware.

On 4/28/16 at approximately 2:40 p.m. an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 was asked if she was aware of two residents in the facility, a male and a female, who had requested to cohort. ASM #1 responded that she was aware and that the situation had been discussed several times in the IDT meetings. ASM #1 was asked where the documentation was that recorded the situation, ASM #1 responded, "The social work section (in the clinical record) should have notes." ASM #1 was made aware that there were no notes in the clinical record. ASM #1 responded that she knew that it had been discussed and that they were "still working on it." A policy was requested regarding documentation.

On 4/28/16 at approximately 4:00 p.m. ASM #1 provide this surveyor with a facility manual titled "Section 1. Documentation" which documented, in part; "General Guidelines: Clinical records are maintained on each patient that are complete, readily accessible and systematically organized. A complete clinical record reports the actual experience of the individual and contains sufficient information to validate patient status and outcomes of care provided. Documentation in the clinical record is expected to be timely and to accurately reflect each patient's condition. Any individual who provides care to the patient may document care in the record."

No further documentation was provided prior to the end of survey.

2. The facility staff failed to document a request

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made by Resident #16 to cohort with a male resident and to document the process taken to accommodate Resident #16's request.

Resident #16 was admitted to the facility on 12/14/14, with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease), depression, hypercholesterolemia (high levels of cholesterol in the blood), anxiety, hypertension (elevated blood pressure), dementia and dysphagia (difficult swallowing).

Resident #16's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/18/16. Resident #16 was coded as a 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was cognitively intact.

During the group interview held on 4/27/16 at 10:30 a.m. Resident #16 stated that she was not allowed to have a male friend in her room. Resident #16 further stated that she had been told (by administration) that if she wanted to spend time with a "male friend" she would have to go to one of the day rooms available in the facility. Resident #16 was asked whether she was in a relationship with a male who lived in the facility. Resident #16 stated that she was in a relationship with (name of Resident #15). Resident #16 stated that together they had asked "them" (administration) to allow them (Resident #15 and Resident #16) to share a room together and that their POAs (power of attorneys) had been notified and were agreeable to them (Resident #15 and Resident #16) living in the same room in the facility. Resident #16 was

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asked whether or not the facility had made any arrangements since the POAs had agreed. Resident #16 stated "they" (administration) had not told her anything, she was still waiting. Resident #16 was asked how long ago she had made the request, Resident #16 responded, "I don't remember but nothing is happening and we really want to do this."

A review of Resident #16's clinical record, including social worker notes, did not reveal any documentation related to Resident #16's request to share a room with a male resident.

A review of Resident #16's care plan dated 3/29/16 did not reveal any information regarding Resident #16's request to cohort with a male resident in the facility.

On 4/28/16 at approximately 2:30 p.m. an interview was conducted with OSM #2, the social worker. OSM #2 was asked if residents in the facility requested to be roomed together, specifically a male and a female, what was the process. OSM #2 stated, "This is under resident rights, I would go to the IDT meeting and discuss the situation." OSM #2 was asked whether or not there was a policy specific to cohorting in the facility. OSM #2 was unable to state whether or not there was a policy. OSM #2 stated, "We have to be mindful of resident rights. We would involve the POAs, whoever is making the decisions for the residents and then figure out the actions to take." OSM #2 was asked to describe her next steps following a discussion with the POAs. OSM #2 stated that she would discuss it with the rest of the team in the IDT meeting. OSM #2 was asked whether or not she would document the situation in the resident's clinical record. OSM #2

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responded that she would usually write a note about the request and the steps taken. OSM #2 was asked specifically about Resident #16 and if she had come to her to request to cohort with a male resident in the facility. OSM #2 stated that she was familiar with the request and had taken the request to the IDT meeting and also had spoken with the POAs for both parties and they were agreeable to the situation. OSM #2 was asked how much time had expired since the request by the residents involved had been made and the POAs had agreed. OSM #2 was unable to say how long she had been working on this. OSM #2 was asked where her documentation was located regarding this situation. OSM #2 stated she had not documented in the record, "I wrote in my personal notes and I can look back and see what I have, but I have destroyed most of my notes, today is my last day and I have been putting everything in the burn box." OSM #2 was asked who was now taking the lead on the request made by the residents. OSM #2 stated that the IDT was aware.

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A policy was requested regarding documentation

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

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical 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. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also included the following information: "As members of the health care team, nurses need to communicate information about clients accurately and in a timely, effective manner."