ManorCare Health Services of Alexandria
1510 Collingwood Road
Alexandria, Virginia 22308
703.765.6107
703.768.6344 fax

ManorCare Health Services

October 9, 2018

Wietske G. Weigel-Delano
LTC Supervisor
Office of Licensure and Certification
Division of Long Term Care Services

Dear Ms. Wietske G. Weigel-Delano,

Re: Plan of Corrections

ManorCare Health Services of Alexandria

Provider Number: 495011

Here is this revised plan of corrections for ManorCare Health Services of Alexandria for the standard survey ending August 30, 2018 for your consideration and acceptance. The date of compliance has been revised for all indicated corrections.

Sincerely,

Leslie Jaffey, LNHA
Administrator

COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

M. Norman Oliver, MD, MA
State Health Commissioner

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

September 14, 2018

Ms. Leslie Jaffey, Administrator
Manorcare Health Services-Alexandria
1510 Collingwood Road
Alexandria, VA 22308-1605

RE: Manorcare Health Services-Alexandria
Provider Number 495011

Dear Ms. Jaffey:

An unannounced standard survey, ending August 30, 2018, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Two complaints were investigated during the survey. One complaint was substantiated, with no deficiencies. One complaints was unsubstantiated, with no deficiencies.

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

Survey Results

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

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

Plan of Correction (PoC)

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

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

To be considered acceptable, the PoC must:

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

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

Informal Dispute Resolution

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

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

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

Recommended Remedies

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

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).
- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,
- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

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

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

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

Survey Response Form

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

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

Sincerely,

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

Enclosure

cc: Joani Latimer, State Ombudsman
Bertha Ventura, Dmas (Sent Electronically)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495011	A. BUILDING _____ B. WING _____	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ALEXANDRIA	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 8/30/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/28/18 through 8/30/18. Two complaints were investigated during this survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 84 bed certified bed facility was 78 at the time of the survey. The survey sample consisted of 24 current Resident record reviews (Residents #28, 46, 17, 66, 41, 70, 19, 1, 71, 11, 8, 60, 58, 6, 68, 33, 15, 12, 38, 7, 9, 35, 2, and 13) and six closed record reviews (Residents #124, 74, 76, 43, 180 and 225).	F 000	F 584 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Leslie | TITLE: Administrator | (X6) DATE: 10/9/18

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

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F 584	Continued From page 1 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure a homelike environment for 24 of 52 resident rooms. The facility staff failed to maintain the walls in 24 resident's rooms in good repair and failed to ensure television cabinets had doorknobs and that furniture was in good repair.	F 584	I. Corrective Action The Maintenance Director has created work orders addressing all indicated repairs for residents identified. A strategic plan has been initiated to ensure that all indicated repairs are completed within 60 days. **Resident # 4**, A-side, doorknob replaced on both doors of television table. Wall behind head of bed repaired. **Resident # 5**, A-side, wall behind head of bed, left of bed and wall adjacent to bathroom door repaired. Door knob replaced on both doors of television table. **Resident # 8**, A-side, wall across from foot of the bed, and to the right of the bed repaired. B-side, small cabinet identified was removed and replaced. **Resident # 9**, A-side, wall behind the head of the bed repaired. **Resident # 11**, A-side, door knob replaced on both doors of television table. B-side, wall protector next to bed repaired. **Resident # 14**, A-side, wall behind head of the bed repaired. **Resident # 15**, A-side, wall behind head of the bed repaired. B-side, section of wall behind head of the bed was painted and door knob replaced on both doors of television cabinet. **Resident # 17**, A-side & B-side, wall behind head of the bed was repaired.	

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F 584	Continued From page 2 The findings include: On 08/28/18 at approximately 3:05 p.m., observations of resident room revealed the following: "Resident room # 4, A-side revealed a television table with double doors on the bottom for storage. Each door was missing a doorknob and the wall behind head of bed was observed chipped and gouged. "Resident room # 5, A-side revealed the wall behind the head of bed, to the left of bed and the wall adjacent to bathroom door were observed chipped and gouged. Further observation revealed a television table with double doors on the bottom for storage. Each door was missing a doorknob. "Resident room # 8, A-side revealed the wall across from foot of the bed, and to the right of the bed were observed chipped and gouged. Observation of the B-side of the room revealed a small cabinet with a drawer and a door on the bottom. Further observation of the cabinet revealed it was stained and the trim was chipped. "Resident room # 9, A-side of the room revealed the wall behind the head of bed was chipped and gouged. "Resident room # 11, A-side of the room revealed a television table with double doors on the bottom for storage. Each door was missing a doorknob. Observation of the B-side of the room revealed a wall protector next to the bed falling off the wall.	F 584	**Resident # 19**, wall behind the head of the bed repaired. **Resident # 20**, A-side, wall behind the head of the bed repaired. **Resident # 22**, A-side and B-side door knobs on television cabinets repaired. **Resident # 24**, wall behind the head of the bed was repaired. **Resident # 27**, A-side, wall behind the head of the bed repaired. **Resident # 29**, A-side & B-side, wall behind the head of the bed repaired. **Resident # 30**, B-side, wall behind the head of the bed repaired. **Resident # 36**, plate cover for phone jack on the wall to the left of the bed replaced. **Resident # 38**, A-side, wall behind the head of the bed repaired. After notification from surveyor of electrical receptacle box hanging out of wall, Maintenance Director repaired electrical receptacle box immediately. **Resident # 39**, B-side, wall behind the head of the bed repaired. **Resident # 40**, A-side, wall behind the head of the bed repaired. **Resident # 41**, B-side, wall behind the head of the bed repaired. **Resident # 43**, B-side, wall behind the head of the bed repaired. **Resident # 44**, B-side, wall behind the head of the bed repaired. **Resident # 45**, A-side & B-side, wall behind the head of the bed repaired. **Resident # 46**, A-side & B-side, wall behind the head of the bed repaired.	

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F 584	Continued From page 3 *Resident room # 14, A-side of the room revealed the wall behind the head of bed was chipped and gouged. *Resident room # 15, A-side of the room revealed the wall behind the head of bed was chipped and gouged. Observation of the B-side of the room revealed a section of wall behind the head of the bed was unpainted and the television cabinet was missing doorknobs on each door of the cabinet. *Resident room # 17, A-side and B-side of the room revealed the wall behind the head of the bed of the A-side bed and the B-side bed was chipped and gouged. *Resident room 19, a private room, revealed the wall behind head of the bed was chipped and gouged. *Resident room 20, A-side of the room revealed the wall behind the head of bed chipped and gouged. *Resident room 22, A and B-side of the room revealed television cabinets on each side of the room with double doors on the bottom for storage. Further observation of the television cabinets revealed a missing a missing doorknob on each cabinet. *Resident room 24, a private room, revealed the wall behind the head of bed was chipped and gouged. *Resident room 27, A-side of the room revealed the wall behind the head of bed was chipped and gouged.	F 584	**II. Identification** An inspection of resident rooms will be completed by administration to determine any other needed repairs. Work orders will be created to address needed repairs and ensure that all identified needed repairs are completed. **III. Systemic Changes** Staff education has been completed to ensure that all facility staff are knowledgeable of how to identify a needed repair and how to communicate needed repair to maintenance. **IV. Monitoring** Administration and/or designee will complete weekly room inspections for 1 month to ensure completed repairs and identify any additional needed repairs. The facility will then complete monthly inspections on resident rooms to identify needed repairs times two months. The facility's Quality Assurance and Assessment Committee will review the weekly/monthly inspection reports to determine trends and ways to address and improve the need for facility repairs. The Administrator and Maintenance Director will work with the corporate Manager of Plant Operations on strategies to improve wall and furniture damage.	

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F 584	Continued From page 4 "Resident room 29, A-side and B-side of the room revealed the wall behind the head of the bed of the A-side bed and the B-side bed was chipped and gouged. "Resident room 30, B-side of the room revealed the wall behind the head of bed was chipped and gouged. "Resident room 36, a private room revealed a missing plate cover for the phone jack on the wall to the left of the bed. "Resident room 38, A-side of the room revealed the wall behind the head of bed was chipped and gouged, an electrical receptacle box containing a two-plug outlet with the bed plugged into the outlet. Further review of the electrical receptacle box revealed it was hanging out of the wall. "Resident room 39, B-side of the room revealed the wall behind the head of bed was chipped and gouged. "Resident room 40, A-side of the room revealed the wall behind the head of bed was chipped and gouged. "Resident room 41, B-side of the room revealed the wall behind the head of bed was chipped and gouged. "Resident room 43, B-side of the room revealed the wall behind the head of bed was chipped and gouged. "Resident room 44, B-side of the room revealed the wall behind the head of bed was chipped and gouged.	F 584	V. Date of Compliance 10/04/2018	

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MANORCARE HEALTH SERVICES-ALEXANDRIA	1610 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

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F 584	Continued From page 5 "Resident room # 45, A-side and B-side of the room revealed the wall behind the head of the bed of the A-side bed and the B-side bed was chipped and gouged. Further observation of the room revealed the wall across from the foot of the bed on the A-side of the room was chipped and gouged. "Resident room # 46, A-side and B-side of the room revealed the wall behind the head of the bed of the A-side bed and the B-side bed was chipped and gouged. On 08/29/18 at 3:30 p.m., a tour and observation of the resident's rooms was conducted with ASM (administrative staff member) # 1, administrator, and OSM (other staff member) # 1, director of maintenance. Upon observations of resident rooms # 4, # 5 and # 8 ASM # 1 and OSM # 1 acknowledged that the television cabinet doors were missing doorknobs, the walls in all three rooms were in poor repair and the cabinet in resident Room # 8 was not in good repair. ASM # 1 and OSM # 1 were informed of this surveyor's observation of 21 other resident rooms revealed the same type of conditions. Before proceeding to observe the next resident room ASM # 1 asked for a list of the resident rooms that were observed, and stated she thought there were work orders for some of the rooms, and would provide those work orders. ASM # 1 and OSM # 1 further stated that they believed this surveyor's observations and findings and did not need to observe each room listed above. On 08/29/18 at approximately 4:00 p.m., OSM # 1 provided this surveyor with copies of work orders dated 08/01/18 through 08/29/18. Review of the	F 584		

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F 584	Continued From page 6 work orders failed to evidence repairs to the walls and /or the missing doorknobs on the television cabinets for resident room numbers 2, 4, 5, 8, 9. 11, 14, 15, 17, 19. 20, 22, 24, 27, 29, 30, 36, 38, 39, 40, 41, 43, 45, and 46. On 08/30 18 at 7:45 a.m., an interview was conducted with ASM (administrative staff member) # 1, administrator. ASM # 1 stated she had reviewed resident room numbers 2, 4, 5, 8, 9. 11, 14, 15, 17, 19. 20, 22, 24, 27, 29, 30, 36, 38, 39, 40, 41, 43, 45, and 46 and agreed with this surveyor's findings and observations. ASM # 1 stated, "We put all those rooms on the work order system yesterday. ASM # 1 further stated, "In July I had a company come in and repaired walls and painted rooms. We are in the process of updating the facility. I also had a design team come in a couple of months ago and we had furniture ordered including the wardrobes but the night stands and television stands have not been ordered yet, but will be next." On 08/3/18 at approximately 8:15 a.m., an interview was conducted with OSM (other staff member) #1, director of maintenance. When asked to describe the process for identifying needed repairs and making repairs to resident rooms, OSM # 1 stated, "If an employee finds something in need of repair, they put it in the TELS system (electronic work order system) or they tell their supervisor and they put it in the system. I check the TELS several times a day and the work is prioritized. If it is an immediate problem like a water leak, they (staff) get a hold of me immediately and take care of it." When asked if he make routine rounds to check the resident's rooms, OSM # 1 stated, "Usually every morning when I get in about at six in the morning	F 584		

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F 584	Continued From page 7 I check lights, water anything obvious. I don't go to the residents' rooms because it's too early and they are still asleep. During the course of the week I usually get to all the resident's rooms but if I get involved in a project I don't get to it." On 08/30/18 at approximately 12:25 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit.	F 584	F 656 The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656	cited have been or will be corrected by the date indicated. It is the practice of the facility to develop and/or implement comprehensive person-centered care plans **I. Corrective Action** 1 resident #41's MD was notified of BP not taken and new order obtained and meds now being administered per MD's order. 1b. resident's #41's nurse was re-educated on offering non-pharmacological intervention prior To administration of as needed medication Resident #2's nurse was re-educated on Offering non-pharmacological intervention prior To administration of as needed medication	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ALEXANDRIA	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

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F 656	Continued From page 8 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for five of 30 residents in the survey sample, Resident #41, 2, 28, 35, 11. 1a. The facility staff failed to implement Resident #41's comprehensive care plan to administer blood pressure medication per physician's order. 1b. The facility staff failed to implement Resident #41's comprehensive care plan and attempt non-pharmacological pain interventions prior to the administration of prn (as needed) pain medications. 2. The facility staff failed to implement Resident #2's comprehensive care plan and attempt	F 656	Upon notification by surveyor resident #28's air mattress was immediately turned on, resident assessed for any discomfort and re-education provided to nursing staff on checking function of air mattress. pon notification by the surveyor, resident #35's Head-of-bed was elevated as ordered and nursing staff re-educated on ensuring that head of bed stays elevated post feeding. esident #11's oxygen is now being administered per MD's order. esident #11's nurse was re-educated on offering non-pharmacological intervention prior to administration of as needed medication. **II. Identification** All residents residing in the facility have the potential to be affected by the alleged deficient practice. **III. Systemic Changes** Interdisciplinary Team (IDT) will be re-educated to develop and/or implement comprehensive care plan for all residents.	

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F 656	Continued From page 9 non-pharmacological pain interventions prior to the administration of prn (as needed) pain medications. 3. The facility staff failed to ensure Resident #28's air mattress was on and functioning per comprehensive plan of care on 8/29/18. 4. The facility staff failed to implement the comprehensive care plan and elevate Resident #35's head of bed to 30-45 degrees one hour post tube feeding. 5a. The facility staff failed to follow Resident # 11's comprehensive care plan for the administration of oxygen. 5b. The facility staff failed to follow Resident # 11's comprehensive care plan for the implementation of non-pharmacological interventions. The findings include: 1. Resident #41 was admitted to the facility on 7/13/18 with diagnoses that included but were not limited to muscle weakness, high blood pressure, and atrial fibrillation. Resident #41's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/20/18. Resident #41 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #41's most recent POS (physician order summary) signed by the physician on 8/6/18, revealed the following order:	F 656	**IV. Monitoring** DON and/or designee will complete five (5) random audits of residents to ensure that comprehensive care plan has been implemented. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or action. **V. Date of Compliance** 10/04/2018	

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F 656	Continued From page 10 "Lisinopril 25 mg (milligrams) po (by mouth) qd (every day) for HTN (high blood pressure), Hold for SBP (systolic blood pressure) (2) less than 120." This order was initiated on 8/1/18. Review of Resident #41's August 2018 MAR (medication administration record) revealed Lisinopril was administered 8/1/18 through 8/29/18. There were no documented blood pressures on the MAR. Review of the vital sign tab on PCC (point click care) in the electronic record, revealed blood pressures were obtained and documented on the following dates: 8/1/18, 8/2/18, 8/3/18, 8/5/18, 8/12/18, 8/19/18, and 8/26/18. There was no evidence of blood pressures for the remaining 22 days in the clinical record. Resident #41's cardiac care plan dated 7/17/18 documented in part, the following: "Cardiac disease related to Hypertension Goal: Will experience effective symptom management over the quarter. Interventions: Administer medication per physician's order." On 8/29/18 at 9:57 a.m., an interview was conducted with Resident #41. When asked how often her blood pressure was checked, Resident #41 stated that she barely gets her blood pressure checked and was not sure if it was supposed to be more frequent. On 8/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #41's nurse. When asked about the process staff follows when a resident has parameters for blood pressure medication, LPN	F 656		

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F 656	Continued From page 11 #2 stated that nursing should check the resident's blood pressure, and if the blood pressure is out of range for the medication to be administered, then the medication should be held. LPN #2 stated, "The physician also needs to be made aware if the blood pressure medication is held." LPN #2 confirmed that blood pressure should be checked every time prior to administering blood pressure medications with parameters. When asked where blood pressures were documented, LPN #2 stated that blood pressure should be documented on the MAR. When asked if Resident #41's blood pressures were documented on her MAR, LPN #2 confirmed that blood pressures were missing and not documented on the MAR. LPN #2 stated blood pressures may have been documented in the nursing notes. This writer showed LPN #2 Resident #41 is nursing notes. LPN #2 confirmed that blood pressures for the missing dates above were not documented. When asked how she would know that Resident #41's blood pressures were checked prior to the administration of Lisinopril, LPN #2 stated that she wouldn't know. When asked if she checks Resident #41's blood pressure prior to the administration of Lisinopril, LPN #2 did not answer. When asked if the order was followed, LPN #2 stated that the above order was not followed. When LPN #2 was asked the purpose of the care plan, LPN #2 stated that the purpose of the care plan was to alert nursing staff on the needs of the resident. When asked if the care plan should be followed, LPN #2 stated that the care plan should be followed to ensure the resident is receiving appropriate care. When asked if Resident #41's cardiac care plan was followed, if the resident's blood pressures were not checked per physician's orders, LPN #2 stated that the care plan was not being followed.	F 656		

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F 656	Continued From page 12 On 8/30/18 at 12:25 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the Quality Assurance Consultant was made aware of the above concerns. The facility policy titled, "Interdisciplinary Care Planning," documents in part, the following: "Purpose: To provide guidelines on the process of interdisciplinary care planning. The patient's care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individuals patient's needs. It also identifies the types and methods of care that the patient should receive...Implementation: Once the care plan is developed, the staff must implement the interventions identified in the care plan. These may include, but is not limited to: administering treatments and medications, performing therapies, and participating in activities with the patient." (1) Lisinopril is used to treat high blood pressure and heart failure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010968/?report=details. (2) Systolic blood pressure "is the pressure caused by your heart contracting and pushing out blood. Normal blood pressure for adults is defined as a systolic pressure of less than 120." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/health/high-blood-pressure.	F 656		

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F 656	Continued From page 13 1b. The facility staff failed to implement Resident #41's comprehensive care plan and attempt non-pharmacological pain interventions prior to the administration of prn (as needed) pain medications. Resident #41 was admitted to the facility on 7/13/18 with diagnoses that included but were not limited to muscle weakness, high blood pressure, and atrial fibrillation. Resident #41's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/20/18. Resident #41 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #41's July and August 2018 POS (physician order summary) revealed the following order: "Tramadol (1) 50 mg (milligrams) 1 tab (tablet) by mouth every 8 hours as needed for pain." Review of Resident #41's July 2018 MAR (medication administration record) revealed that Resident #41 received Tramadol on the following dates: 7/18/18 at 1 p.m. 7/19/18 at 9 a.m. 7/20/18 at 9 a.m. 7/23/18 at 9:00 a.m. 7/24/18 at 8:00 a.m. 7/27/18 at 10:00 p.m. For 7/27/18, there was no pain scale, follow up pain scale/evaluation or location of pain documented on the back of the MAR. There was	F 656		

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F 656	Continued From page 14 no evidence that non-pharmacological pain relief interventions were attempted prior to the administration of Tramadol for all above dates. Review of Resident #41's July nursing notes failed to evidence that non-pharmacological pain interventions were attempted prior to the administration of Tramadol on the above dates. There were no nursing notes that addressed Resident #41's pain on 7/27/18. Review of Resident #41's August 2018 MAR (medication administration record) revealed that Resident #41 received Tramadol on the following dates: 8/6/18 8/8/18 8/11/18 8/18/18 8/20/18 8/22/18 8/28/18 For 8/8/18, 8/11/18, 8/18/18 and 8/22/18 there was no evidence of location of pain documented on the back of the August MAR. There was no evidence that non-pharmacological pain relief interventions were attempted prior to the administration of Tramadol for all above dates. August nursing notes could not be found in the clinical record regarding Resident #41's pain for the above dates. Review of Resident #41's pain care plan dated 7/13/18 documented the following intervention: "Implement non-pharmacological interventions such as music, positioning, or OOB (out of bed) to motorized wheelchair to assist with pain and	F 656		

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F 656	Continued From page 15 monitor for effectiveness." On 8/29/18 at 9:57 a.m., an interview was conducted with Resident #41. When asked if staff tried other things such a hot therapy, massage etc. prior to giving a prn pain medication, Resident #41 stated that she was just given a pill. On 8/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #41's nurse. When asked about the process staff follows when administering prn (as needed) pain medications, LPN #2 stated that nurses should be asking the patient their level of pain on a scale from 1-10 (10 being the worst possible pain), and then go check the prn (as needed) pain medications. LPN #2 stated that she would ask the pain level, when it started, and see what pain medications she can give. LPN #2 stated that once pain medication is administered, she would go back and reassess pain after 30 minutes. LPN #2 stated that this information should be documented on the back of the MAR. When asked what was documented on the back of the MAR, LPN #2 stated, "Time, date, my initials, type of medication, pain level." When asked if the location of pain was part of the pain assessment, LPN #2 confirmed that it was and that location of pain should be documented. LPN #2 stated that if the pain assessment was not on the back of the MAR, that it may be documented in a nursing note. When asked if other interventions for pain relief should be attempted, prior to administering pain medications, LPN #2 stated that she would attempt sometimes. LPN #2 stated that you could tell by talking to the resident if non-pharmacological pain relief interventions would work. LPN #2 stated the resident may also refuse. When asked if	F 656		

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F 656	Continued From page 16 non-pharmacological interventions should be at least offered prior to giving prn pain medications, LPN #2 stated, "Yes, it should be done each time before giving medication." When asked if it was documented anywhere in the clinical record that non-pharmacological interventions were attempted or offered, LPN #2 stated that that information should be documented in a progress note. When asked why it was important to attempt non-pharmacological pain relief interventions prior to administering pain medications, LPN #2 stated that the pain could be managed by other means. LPN #2 confirmed the above concerns. LPN #2 stated that Resident #41 requested her pain medication and that the resident knew what she wanted. When asked again if non-pharmacological should be offered or attempted before any as needed pain medication is given, LPN #2 stated yes. When LPN #2 was asked the purpose of the care plan, LPN #2 stated that the purpose was to alert nursing staff on the needs of the resident. When asked if the care plan should be followed, LPN #2 stated that the care plan should be followed to ensure the resident is receiving appropriate care. LPN #2 confirmed that Resident #41's care plan was not being followed if there was no evidence that non-pharmacological pain interventions were being offered or attempted. On 8/30/18 at 12:25 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the Quality Assurance Consultant was made aware of the above concerns. (1) Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p.	F 656		

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F 656	Continued From page 17 1197. 2. The facility staff failed to implement Resident #2's comprehensive care plan and attempt non-pharmacological pain interventions prior to the administration of prn (as needed) pain medications. Resident #2 was admitted to the facility on 5/17/18 with diagnoses that included but were not limited to type two diabetes mellitus, hypothyroidism, post stroke, and back pain with spinal stenosis. Resident #2's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/24/18. Resident #2 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #2's was coded as requiring limited assistance from one staff member with locomotion on and off the unit; extensive assistance with one staff member with transfers, personal hygiene, and bathing; and total dependence on staff with dressing. Review of Resident #2's July and August 2018 POS (physician order summary) documented the following order: "Ibuprofen 200 mg (milligrams), take two tablets po (by mouth) q (every) 8 hours prn (as needed) headache." Review of Resident #2's July and August 2018 MAR (medication administration record) revealed that she received Ibuprofen on the following dates and times: 7/25/18 at 3:00 p.m. and 7/31/18 at 12:00 p.m., 8/3/18 at 1:00 a.m., and 8/25/18 at 3:30 a.m.	F 656		

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F 656	Continued From page 18 Review of the July and August 2018 MARS failed to evidence pain scales for the above dates follow up pain assessments and non-pharmacological interventions attempted prior to the administration of Ibuprofen. Review of Resident #2's nursing notes revealed a note dated 8/25/18 that documented in part, the following: "Resident c/o (complaints) pain 3/10. Ibuprofen (sic) administered 400 mg resulting in pain 0/10..." This note did not address non-pharmacological interventions attempted prior to the administration of the Ibuprofen. No other notes could be found in the clinical record regarding Resident #2's pain on the above dates. Resident #2's pain care plan dated 5/17/18 documented the following intervention: "Implement non-pharmacological interventions such as music, positioning or other activities of choice to assist with pain and monitor for effectiveness." On 8/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked about the process staff follows when administering prn (as needed) pain medications, LPN #2 stated that nurses should be asking the patient their level of pain on a scale from 1-10 (10 being the worst possible pain), and then go check the prn (as needed) pain medications. LPN #2 stated that she would ask the pain level, when it started, and see what pain medications she can give. LPN #2 stated that once pain medication is administered, she would go back and reassess pain after 30 minutes. LPN #2 stated that this	F 656		

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F 656	Continued From page 19 information should be documented on the back of the MAR. When asked what was documented on the back of the MAR, LPN #2 stated, "Time, date, my initials, type of medication, pain level." When asked if location of pain was part of the pain assessment, LPN #2 confirmed that it was and that location of pain should also be documented. LPN #2 stated that if the pain assessment was not on the back of the MAR, that it may be documented in a nursing note. When asked if other interventions for pain relief should be attempted first, prior to administering pain medications, LPN #2 stated that she would attempt sometimes. LPN #2 stated that you could tell by talking to the resident if non-pharmacological pain relief interventions would work. LPN #2 stated that the resident may also refuse. When asked if non-pharmacological interventions should be at least offered prior to giving as needed pain medications, LPN #2 stated, "Yes, it should be done each time before giving medication." When asked if it was documented anywhere in the clinical record that non-pharmacological interventions were attempted or offered, LPN #2 stated that that information should be documented in a progress note. When asked why it was important to attempt non-pharmacological pain relief interventions prior to administering pain medications, LPN #2 stated that the pain could be managed by other means. LPN #2 confirmed the above concerns. When LPN #2 was asked the purpose of the care plan, LPN #2 stated the care plan was to alert nursing staff on the needs of the resident. When asked if the care plan should be followed, LPN #2 stated that the care plan should be followed to ensure the resident is receiving appropriate care. LPN #2 confirmed that the care plan was not being followed if there was no	F 656		

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	495011	A. BUILDING _____ B. WING _____	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ALEXANDRIA	1610 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

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F 656	Continued From page 20 evidence that non-pharmacological pain interventions were being offered or attempted. On 8/30/18 at 12:25 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the Quality Assurance Consultant was made aware of the above concerns. (1) Ibuprofen is a non-steroidal anti-inflammatory drug used to treat mild to moderate pain. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010648/?report=details. 3. The facility staff failed to ensure Resident #28's air mattress was on and functioning per comprehensive plan of care on 8/29/18. Resident #28 was admitted to the facility on 2/9/18 with diagnoses that include but were not limited to severe protein deficiency, left and right sided weakness post stroke, coronary arterial disease and chronic embolism and thrombosis of unspecified deep veins of the lower extremities. Resident #28's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 6/27/18. Resident #28 was coded as being severely impaired in cognitive function scoring 02 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #28 was coded in section M (Skin Conditions) as having one stage three (1) pressure ulcer* that was present upon admission, two stage four (2) pressure ulcers that were present upon	F 656		

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F 656	Continued From page 21 admission and two unstageable (3) pressure sores that were present upon admission. Resident #28 was coded in Section O (Special Treatments, Procedures, Programs) as receiving hospice services. Resident #28 was also coded as having severe weight loss in Section K (Swallowing/Nutritional Status). Resident #28 was coded as requiring extensive assistance from one staff member with all ADLs (activities of daily living). Review of Resident #28's weekly skin/wound note dated 8/22/18 documented the following wounds: - "Left medial ankle (stasis ulcer) (4) measuring 3 cm (centimeters) (L) (length) X 2.5 cm (W) (width) X 0.2 cm (D) (depth). - Left lateral ankle (stasis ulcer) measuring 3 cm X 2.5 cm X 0.2 cm. - Left buttock (Stage IV (four) pressure ulcer) measuring 4 cm X 8 cm X 0.2 cm. - Left heel (Stage III) measuring 3 cm X 3 cm X 0. - Right heel (unstageable) measuring 3 cm X 4 cm X 0.2 cm. - Right lateral foot (unstageable) measuring 2 cm X 2 cm X 0.2 cm. - Left medial foot (stasis ulcer) 2 cm X 7.8 cm X 0.2 cm." Review of Resident #28's August 2018 (Physician Order Summary) revealed that each wound had a specific treatment in place. Staff were documenting that treatments were being completed on the August 2018 TAR (treatment administration record). Review of Resident #28's August 2018 skin care plan dated 2/9/18 and revised 5/1/18, documented the following: "At risk for alteration in	F 656		

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F 656	Continued From page 22 skin integrity related to: immobility, incontinence, normal progressive decline in disease process...Interventions: Pressure redistributing device to bed..." Further review of Resident #28's care plan documented the following: "Pressure Ulcer to L (left buttock) related to: impaired mobility due to generalized weakness, nutritional deficit...Interventions: Air mattress on bed." On 8/28/18 at 1:38 p.m., an observation was made of Resident #28. She was sleeping in bed. She had an air mattress to her bed that was on and functioning. On 8/28/18 at 4:34 p.m., an observation was made of Resident #28. She was sleeping in bed. She had an air mattress to her bed that was on and functioning. On 8/29/18 at 7:43 a.m., an observation was made of Resident #28. She was sleeping in bed. Her air mattress was off and was unplugged. On 8/29/18 at 8:53 a.m., a CNA (certified nursing assistant) (CNA #2) had walked out of Resident #28's room carrying her meal tray. When asked if she had just left Resident #28's room, CNA #2 stated that she attempted to feed Resident #28 and that her appetite has been poor for quite some time. CNA #2 confirmed that she was just in the resident's room. On 8/29/18 at 8:54 a.m., this writer made an observation of Resident #28's room. Her air mattress was unplugged and off. On 8/29/18 at 9:07 a.m. and 9:27 a.m., observations were made of Resident #28. Resident #28 was lying in bed. Her air mattress	F 656		

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F 656	Continued From page 23 continued to be unplugged and off. On 8/29/18 at 10:11 a.m., CNA #2 was observed walking into Resident #28's room. This writer followed CNA #2 into her room. CNA #2 explained that she was about to get Resident #28 out of bed for an activity. When asked what CNA #2 noticed about Resident #28's mattress, CNA #2 looked at the mattress and stated that it was off. CNA #2 tried to turn on the air mattress and it wouldn't turn on. CNA #2 then looked underneath Resident #28's bed and stated that it (the air mattress) was unplugged. CNA #2 then plugged Resident #28's air mattress back in. When asked how long the mattress had been like that, CNA #2 stated that she thought the air mattress was on when she washed her up but was not sure. When asked what time she washed the resident up, CNA #2 stated, "Just now." When CNA #2 was informed of the above observations, CNA #2 stated that she did not check the mattress that morning. On 8/29/18 at 10:13 a.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #28's nurse. When asked who was responsible for ensuring air mattresses were on and functioning, LPN #2 stated it was the nurse's responsibility, including CNAs to ensure an air mattress is on and functioning properly. When asked if she had been in Resident #28's room that morning, LPN #2 stated that she had been in her room during the early morning. When asked if Resident #28 should have a functioning air mattress on her bed, LPN #2 stated, "Yes." LPN #2 stated Resident #28's air mattress was on and functioning early that morning. When asked why Resident #28 needed an air mattress, LPN #2 stated that Resident #28 had ulcers to her feet	F 656		

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F 656	Continued From page 24 and sacrum. When LPN #2 was informed of the above observations, LPN #2 stated that hospice must have accidentally unplugged her air mattress when they came in that morning. LPN #2 stated that hospice usually comes in by 7 a.m. on Wednesdays. When asked if staff should be checking her mattress every time they enter her room, LPN #2 confirmed that staff should. On 8/29/18 at approximately 10:30 a.m., ASM #2 was asked to see Resident #28's wound care. ASM #2 stated that the physician and nurse had already completed it early that morning. This writer requested to see Resident #28's wound care on 8/30/18. Review of Resident #28's skin/wound note dated 8/29/18, documented the following pressure and stasis ulcers along with new orders for each wound: *L (left buttock): Stage IV (four): Altered skin integrity measuring at 10 cm (centimeters) (L) (length) X 13.0 cm (W) (width) X 0.2 cm (D) (depth). Tissue type is 100 percent granulating with moderate serous drainage...This wound was present upon admission. Treatment: 0.25 percent strength Dakins (5) solution soaked with gauze and cover with dry dsg (dressing) daily. Left heel- Stage III (three) and left medial foot stasis ulcer /PVD (peripheral vascular disease) etiology per wound MD (medical doctor) (Now merged): Altered skin integrity measuring at 9.0 (L) X 22.0 (W) x 0.6 cm (D)...This wound emerged from multiple wounds on same location on admission. Treatment: Iodosorb (6) to open area and Bactroban (7) to scabbed area. Cover with dry dressing.	F 656		

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F 656	Continued From page 25 Right heel and right lateral foot unstageable ulcers (Now merged) stasis ulcer/PVD etiology per wound MD. Altered skin integrity measuring at 9.0 (L) X 22.0 (W) X 0.6 cm (D)...Treatment: Iodosorb to open area and Bactroban to scabbed area. Cover with dry dressing." On 8/30/18 at 11:27 a.m., further interview was conducted with LPN #2. When LPN #2 was asked the purpose of the care plan, LPN #2 stated the care plan was to alert nursing staff on the needs of the resident. When asked if the care plan should be followed, LPN #2 stated that the care plan should be followed to ensure the resident is receiving appropriate care. When asked if Resident #28's care plan for an air mattress Resident #28's bed was followed, if the air mattress was off and unplugged, LPN #2 stated that the care plan was not being followed. On 8/30/18 at 9:09 a.m., wound care observation was conducted with RN (registered nurse) #4, the wound care nurse and LPN #1. There were no concerns related to the above wounds or wound care. On 8/30/18 at 12:25 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the Quality Assurance Consultant was made aware of the above concerns. *A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen	F 656		

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F 656	Continued From page 26 in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155. (1) Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable. This information was obtained from: The National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. (2) Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. This information was	F 656		

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F 656	Continued From page 27 obtained from: The National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. (3) Unstageable:Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed. This information was obtained from The National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. (4) Stasis Ulcer (Venous leg ulcers) (VLUs) are defined as open lesions between the knee and ankle joint that occur in the presence of venous disease. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4144244/. (5) Dakins Solution- antimicrobial used to prevent and treat infections of the skin and wound. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=9906e5fe-7bf5-4d99-8107-c048bb5e42d5. (6) Iodosorb is a powder containing iodine, which is a suitable dressing for granulating wounds such as venous ulcers. This information was obtained from The National	F 656		

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F 656	Continued From page 28 Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/3926169. (7) Bactroban- an antibiotic that is used primarily for the treatment of primary and secondary skin disorders, nasal infections, and wound healing. This information was obtained from The National Institutes of Health. https://pubchem.ncbi.nlm.nih.gov/compound/Mupirocin#section=Top. 4. The facility staff failed to implement the comprehensive care plan and elevate Resident #35's head of bed to 30-45 degrees one hour post tube feeding. Resident #35 was admitted to the facility on 4/2/2009 and readmitted on 7/29/2014 with diagnoses that included but were not limited to cerebrovascular disease (stroke), dysphagia (difficulty swallowing with NPO (nothing by mouth) status, and vascular dementia. Resident #35's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/11/18. Resident #35 was coded as severely impaired in cognitive function scoring 02 out of possible 15 on the BIMS (brief interview for mental status exam). Resident #35 was coded as requiring total dependence on two of more staff with eating, locomotion, toileting, bathing, and personal hygiene; and extensive assistance from staff with transfers. Resident #35 was coded in Section K (Swallowing/Nutritional Status) as having a feeding tube in place. Review of Resident #35's August 2018 POS	F 656		

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F 656	Continued From page 29 (physician order summary) documented the following order: "Jevity 1.2 at 84 ml (milliliters) an hour. Start at 4 p.m. and run until 1176 mls have infused via gast (gastronomy tube) (1)." Review of Resident #35's comprehensive care plan dated 7/20/18 documented the following: "Need for feeding tube r/t (related to) dysphagia with NPO (nothing by mouth) status...Interventions: elevate the head of bed 30-45 degrees during and 1 hour post feeding." On 8/29/18 at 7:45 a.m., an observation was made of Resident #35. Her tube feed on was on a running at 84 ml/hr. Her head of bed was elevated at least 30 degrees. On 8/29/18 from 8:00 a.m. until 8:10 a.m., medication pass was observed with Resident #35's nurse, who was also the only medication nurse on the unit. On 8/29/18 at 8:22 a.m., this writer knocked on Resident #35's door. The aide (CNA [certified nursing assistant]) #2 stated that she was providing care to Resident #35. On 8/29/18 at 8:37 a.m., an observation was made of Resident #35. Her tube feed equipment had been disconnected and removed from her room. Resident #35's head of bed was completely flat. It had not been 1 hour since the tube feeding was last observed up and running. On 8/29/18 at 8:49 a.m., Resident #35's head of bed continued to be completely flat. On 8/29/18 at 9:28 a.m., Resident #35 was observed up in her reclining chair.	F 656		

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F 656	Continued From page 30 On 8/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #35's nurse. LPN #2 was asked when she took down Resident #35's tube feed on 8/29/18. LPN #2 stated she could not remember but that it was when she gave Resident #35 her morning medications and before the aide provided ADL (activities of daily living) care. LPN #2 was asked how the head of bed should be elevated for residents with a tube feed during the feeding and immediately post feeding. LPN #2 stated the head of bed should be elevated 35-40 degrees. When asked why it was important for residents with tube feedings to have the head of bed elevated post feeding, LPN #2 stated that the resident could aspirate. LPN #2 stated the head of bed should never be flat immediately post tube feeding. When asked if she had noticed that Resident #35's head of bed was completely flat yesterday within the one hour post feeding window, LPN #2 stated that she was not aware of this. LPN #2 confirmed that Resident #35's care plan instructed the nursing staff to keep the head of bed elevated to 30-45 degrees one hour post feeding. LPN #2 stated that all nursing staff had access to the care plan. This writer informed LPN #2 of the above observations. LPN #2 confirmed that the care plan was not followed if it was observed that Resident #35's head of bed was completely flat. CNA #2 could not be reached for an interview. On 8/30/18 at 12:25 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the Quality Assurance Consultant was made aware of the above concerns. A request was made to	F 656		

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F 656	Continued From page 31 speak to any CNA from the nursing unit. On 8/30/18 at 12:52 p.m., an interview was conducted with CNA #1. When asked about the process followed by staff when providing ADL care to a resident with a tube feed, CNA #1 stated that she would call the nurse to unplug the feeding so that it is out of the way. CNA #1 stated that she would lower the head of bed to provide care, but not all the way down as the resident could aspirate. CNA #1 stated that immediately after care she would raise the head of bed back up and then call the nurse to restart the feeding. On 8/30/18 at approximately 1 p.m., ASM #2 brought in the facility's enteral feed policy. ASM #2 pointed out that the policy documented that the head of bed should be elevated for a minimum of 30 minutes after feedings are completed. When asked if she expected her staff to follow the facility policy or resident care plan, ASM #2 stated that she did not realize Resident #35's care plan documented an hour and that the care plan should be followed. No further information was presented prior to exit. (1) Gastronomy tube- "Gastrostomy (PEG) is the preferred route of feeding and nutritional support in patients with a functional gastrointestinal system who require long-term enteral nutrition. The primary indication for enteral and parenteral feeding is the provision of nutritional support to meet metabolic requirements for patients with inadequate oral intake." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4069302/	F 656		

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F 656	Continued From page 32 5a. The facility staff failed to follow Resident # 11's comprehensive care plan for the administration of oxygen. Resident # 11 was admitted to the facility on 02/28/18 and a readmission of 07/07/18 with diagnoses that included but were not limited to respiratory failure, (1), anemia, (2), depressive disorder (3), and diabetes mellitus (4). Resident # 11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/07/18, coded Resident # 11 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Under section "O. Special Treatment, Procedures and Programs" Resident # 69 was coded for "C. Oxygen therapy." On 08/28/18 at 1:21 p.m., an observation of Resident # 11 revealed she was dressed, sitting in her wheelchair watching television, receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen flow meter on the oxygen concentrator revealed the oxygen flow rate between two and a half and three liters per minute. On 08/28/18 at 2:30 p.m., an observation of Resident # 11 revealed she was sitting in her wheelchair watching television, receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen flow meter on the oxygen concentrator revealed oxygen flow rate between two and a half and three liters per minute.	F 656		

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F 656	Continued From page 33 On 08/28/18 at 4:30 p.m., an observation of Resident # 11 revealed her sitting in her wheelchair watching television, receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen flow meter on the oxygen concentrator revealed oxygen flow rate at two liters per minute. The POS (physician's order sheet) for Resident # 11 dated "August 2018"documented, "07/07/18 Oxygen at 2l/M (two liters per minute) via (by) nasal cannula continuously." The comprehensive care plan for Resident # 11 dated 07/08/2018 documented, "Focus. Has/At risk for respiratory impairment related to COPD (chronic obstructive pulmonary disease." Under "Interventions" it documented, "Administer oxygen per MD (medical doctor) orders. Date initiated: 07/09/2018." On 08/29/18 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked to describe the purpose of the care plan for a resident LPN # stated, "How to take care of the patient." When asked why is it important to follow the care plan. "Because of the patient's health to make sure they get the right care." When asked if she entered Resident # 11's room the previous day, on 08/28/18, LPN # 2 stated, "Yes I adjusted the oxygen because it was suppose to be at two liters and it was at two and a half." LPN # 2 was asked to review the comprehensive care plan for Resident # 11's oxygen. When asked if the care plan was being followed when the oxygen flow rate was not set according to the physician's orders LPN # 2 stated, "No."	F 656		

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F 656	Continued From page 34 On 08/30/18 at approximately 12:25 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html. (3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 5b. The facility staff failed to follow Resident # 11's comprehensive care plan for the	F 656		

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F 656	Continued From page 35 Implementation of non-pharmacological intervention. The POS (physician's order sheet) for Resident # 11 dated "August 2018" documented, "MAPAP (1) 325MG (milligram) [Tylenol]. 2 (two) tabs (tablets) by mouth every day as needed for Pain - max (maximum) acetaminophen 3-4 GM (grams) daily - check daily total. 07/07/2018." "Tramadol (2) 50 MG (milligram) tablet. 1 (one) tab (tablet) by mouth every 6 (six) hours as needed for pain. 07/07/2018" The MAR (medication administration record) for Resident # 11, dated "August 2018" documented the above orders. The August 2018 MAR failed to evidence the administration of MAPAP. Further review of the August MAR revealed Tramadol 50 MG was administered to Resident #11, on 08/01/18, 08/06/18, 08/12/18 and 08/14/18. Further review of the MAR failed to evidence documentation of non-pharmacological interventions prior to the administration of Resident # 11's prn (as needed) pain medication. Review of "Progress Notes" for Resident # 11 dated 08/01/18 through 08/29/18 failed to evidence documentation of non-pharmacological interventions prior to the administration of Resident # 11's as needed (prn) Tramadol on 08/01/18, 08/06/18, 08/12/18 and 08/14/18. The comprehensive care plan for Resident # 11 dated 07/08/2018 documented, "Focus. At risk for pain related to immobility, gout, neuropathy." Under "Interventions" it documented, "Implement non-pharmacological interventions such as music, watching TV or positioning to assist with pain and monitor for effectiveness. Date initiated:	F 656		

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F 656	Continued From page 36 07/09/2018." On 08/29/18 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked to describe the purpose of the care plan for a resident LPN # stated, "How to take care of the patient." When asked why is it important to follow the care plan. "Because of the patient's health to make sure they get the right care." LPN # 2 was asked to review the comprehensive care plan for Resident # 11's pain. LPN # 2 was asked to review the August MAR and progress notes dated for Resident # 11 dated 08/01/18 through 08/29/18. When asked if there was documentation that non-pharmacological interventions were attempted when Resident # 11 was administered tramadol on 08/01/18, 08/06/18, 08/12/18 and 08/14/18, LPN # 2 stated no. When asked if there was no documentation of non-pharmacological interventions, being attempted could you say it was done, LPN # 2 stated no. When asked if the care plan was being followed when the non-pharmacological interventions were not being implemented, LPN # 2 stated, "No." On 08/30/18 at approximately 12:25 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit. References: (1) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats,	F 656		

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F 656	Continued From page 37 toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html. (2) Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.	F 656	F 658 The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies have been or will be corrected by the date indicated. It is the practice of the facility to follow professional standards. **I. Corrective Action** Resident #11's orders for pain medication has been clarified.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional	F 658		

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F 658	Continued From page 38 standards of practice for one of 30 residents in the survey sample, Resident # 11. The facility staff failed to clarify physician's orders for two as needed pain medications to determine which, as needed pain medication should be administered to Resident #11. The findings include: Resident # 11 was admitted to the facility on 02/28/18 and a readmission of 07/07/18 with diagnoses that included but were not limited to respiratory failure, (3), anemia, (4), depressive disorder (5), and diabetes mellitus (6). Resident # 11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/07/18, coded Resident # 11 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 11 was coded as requiring limited to extensive assistance of one staff member for activities of daily living. Section "J0300 Pain Presence. Ask resident: Have you had pain or hurting at any time in the last 5 days?" coded Resident # 11 as "0 (zero). No." The POS (physician's order sheet) for Resident # 11 dated "August 2018" documented, "MAPAP 325MG (milligram) [Tylenol]. 2 (two) tabs (tablets) by mouth every day as needed for Pain - max (maximum) acetaminophen 3-4 GM (grams) daily - check daily total. 07/07/2018." "Tramadol 50 MG (milligram) tablet. 1 (one) tab (tablet) by mouth every 6 (six) hours as needed for pain. 07/07/2018"	F 658	**II. Identification** All residents residing in the facility have the potential to be affected by the alleged deficient practice. **III. Systemic Changes** Licensed nurses will be educated on medication transcription, clarifying medications, and MAR documentation. **IV. Monitoring** DON and/or designee will complete five (5) random audits of residents EMAR to ensure that orders are transcribed correctly, instructions clarified, and documentation of resident when not available. These audits will be done weekly x four (4) and then monthly x two (2). These audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions. **V. Date of Compliance** 10/04/2018	

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F 658	Continued From page 39 The MAR (medication administration record) for Resident # 11, dated "August 2018" documented the above physician's orders. The August 2018 MAR failed to evidence the administration of MAPAP (Tylenol). Further review of the August MAR revealed Tramadol 50 MG was administered to Resident #11, on 08/01/18, 08/06/18, 08/12/18 and 08/14/18. Review of "Progress Notes" for Resident # 11 dated 08/01/18 through 08/29/18 failed to evidence documentation of Resident # 11's pain location prior to the administration of pm Tramadol on 08/01/18, 08/06/18, 08/12/18 and 08/14/18. The comprehensive care plan for Resident # 11 dated 07/08/2018 documented, "Focus. At risk for pain related to immobility, gout, neuropathy." Under "Interventions" it documented, "Administer pain medication per MD (medical doctor) orders. Date initiated: 07/09/2018." On 08/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked to describe the procedure staff follows for administering two pm (as needed) pain medications without physician ordered parameters, LPN # 2 stated, "I would call the doctor and clarify it." LPN # 2 was asked to review the August 2018 MAR and physician's order for MAPAP and Tramadol for Resident # 11. LPN # 2 was asked how she determines which pain medication to administer. LPN # 2 stated, "When the patients asks for pain meds (medications) she tells me which one she wants." On 08/30/18 at approximately 1:50 p.m., a	F 658		

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F 658	Continued From page 40 telephone interview was conducted with ASM (administrative staff member) # 7, nurse practitioner regarding the administration of Resident # 11's as needed pain medication. When asked about clarification of which, as needed pain medication of MAPAP (Tylenol) and Tramadol should be administered, ASM # 7 stated, "If the pain is really bad they (nurse) should give the Tramadol. The decision is up to the nurse based on the pain level from the patient." When asked if the pain medication should have parameters ASM # 7 stated, "They don't need parameters. I would assume the nurse would know what pain medication to give." On 08/30/18 at approximately 2:05 p.m., a telephone interview was conducted with ASM (administrative staff member) # 8, the facility's medical director regarding the administration of Resident # 11's as needed pain medication. When asked about clarification of which, as needed pain medication of MAPAP (Tylenol) and Tramadol should be administered, ASM # 8 stated, "A pain level number is subjective. It is the discretion of the nurse." On 08/30/18 at approximately 2:30 p.m., an interview was conducted with ASM # 2, director of nursing regarding the administration of Resident # 11's as needed pain medication. ASM # 2 was asked to review the August 2018 MAR and physician's order for MAPAP (Tylenol) and Tramadol for Resident # 11. When asked how a nurse determines which pain medication to administer, ASM # 2 stated, "It depends on the nursing assessment." When asked to describe what the nursing assessment includes for as needed pain medication, ASM # 2 stated, "Get the pain scale zero to ten, ten being worse pain	F 658		

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F 658	Continued From page 41 and the location." When asked to describe at what pain level Resident # 11 should receive MAPAP (Tylenol) and at what pain level Resident # 11 should receive Tramadol, ASM # 2 stated, "I'm not a physician." On 08/30/18 at approximately 2:45 p.m., ASM # 8, the facility's medical director called the facility and spoke with this surveyor stating he wanted to clarify the earlier conversation regarding the administration of prn pain medication. ASM # 8 stated that the nurse's decision is based on the clinical symptoms of the patient at the time." On 08/30/18 at approximately 3:00 p.m. and interview was conducted with ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services and ASM # 3, quality assurance consultant. A request was made for any standard or information such as the nursing practice act and or code of Virginia, evidencing that it is within a nurse's scope of practice, to make the determination of which as needed prn pain medication to administer to residents with orders for more than one as needed pain medications without pain parameters. A request was also made to provide documentation of what a complete physician's order entails. At 4:00 p.m., ASM # 3 stated they were unable to locate the information requested and provided a copy of the facility's policy entitled "Medication and Treatment Guidelines." The facility's policy "Medication and Treatment Guidelines" documented, "General. Medications are administered in accordance with standards of practice and state specific and federal guidelines." Under "Medication and Treatment Orders" it documented, "A complete medication	F 658		

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F 658	Continued From page 42 order includes: date and time; name of patient; name of the medication; form, formula and route of administration; dosage or strength, frequency, including end date orders if applicable; directions for use including the reason for use, diagnosis or clinical indication; medication specific parameters, if applicable; name of the authorized practitioner giving the order; signature of medical practitioner if the order is written; and name, title, and signature of the nurse transcribing/entering the order." On 08/30/18 at approximately 12:25 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services and ASM # 3, quality assurance consultant, were made aware of the findings. When asked what standard of practice the nursing staff follows ASM # 2 and ASM # 3 stated that they follow the facility's policies and procedures. No further information was provided prior to exit. References: (1) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.h	F 658		

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F 658	Continued From page 43 tml. (2) Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html. (3) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (4) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html. (5) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (6) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:	F 658		

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	495011	A. BUILDING _____ B. WING _____	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ALEXANDRIA	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

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F 658	Continued From page 44 https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure residents received treatment and services in accordance with professional standards of practice and the comprehensive care plan for one of 30 residents in the survey sample, Resident #41. The facility staff failed to check Resident #41's blood pressure to ensure it was within the parameters ordered by the physician for administration, prior to administering blood pressure medication on several occasions in August 2018. The findings include: Resident #41 was admitted to the facility on 7/13/18 with diagnoses that included but were not limited to muscle weakness, high blood pressure, and atrial fibrillation. Resident #41's most recent MDS (minimum data set) assessment was an	F 684	F684 The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged dficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to ensure residents receive treatment and services in accordance with professional standards of practice and comprehensive care plans. **I. Corrective Action** Resident #41's doctor was notified and order was clarified **II. Identification** All residents residing in the facility have the potential to be affected by the alleged deficient practice.	

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F 684	Continued From page 45 admission assessment with an ARD (assessment reference date) of 7/20/18. Resident #41 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #41's most recent POS (physician order summary) signed by the physician on 8/6/18, revealed the following order: "Lisinopril (1) 25 mg (milligrams) po (by mouth) qd (every day) for HTN (high blood pressure), Hold for SBP (systolic blood pressure) (2) less than 120." This order was initiated on 8/1/18. Review of Resident #41's August 2018 MAR (medication administration record) revealed Lisinopril was administered 8/1/18 through 8/29/18. There was no evidence of documented blood pressures on the MAR. Review of the vital sign tab on PCC (point click care) in the electronic record, revealed blood pressures were obtained and documented on the following dates: 8/1/18, 8/2/18, 8/3/18, 8/5/18, 8/12/18, 8/19/18, and 8/26/18. There was no evidence of blood pressures being obtained for the remaining 22 days in the clinical record. Resident #41's cardiac care plan dated 7/17/18 documented in part, the following: "Cardiac disease related to Hypertension Goal: Will experience effective symptom management over the quarter. Interventions: Administer medication per physician's order." On 8/29/18 at 9:57 a.m., an interview was	F 684	**III. Systemic Changes** Licensed nurses will be re-educated to administer medications per doctor order. **IV. Monitoring** DON and/or designee will complete 5 random audits of EMAR/ETAR to ensure medications are administered per doctor orders. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or action. **V. Date of Compliance** 10/04/2018	

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F 684	Continued From page 46 conducted with Resident #41. When asked how often her blood pressure was checked, Resident #41 stated that she barely gets her blood pressure checked and was not sure if it was supposed to be more frequent. On 8/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #41's nurse. When asked about the process staff follows when a resident has physician ordered parameters for blood pressure medication, LPN #2 stated that nursing should check the resident's blood pressure, and if the blood pressure is out of range for the medication to be administered, then the medication should be held. LPN #2 stated, "The physician also needs to be made aware if the blood pressure medication is held." LPN #2 confirmed that blood pressure should be checked every time prior to administering blood pressure medications with parameters. When asked where blood pressures were documented, LPN #2 stated that blood pressure should be documented on the MAR. When asked if Resident #41's blood pressures were documented on her MAR, LPN #2 confirmed that blood pressures were missing. LPN #2 stated that blood pressures may have been documented in the nursing notes. This writer showed LPN #2 Resident #41's nursing notes. LPN #2 confirmed that blood pressures for the missing dates were not documented. When asked how she would know that Resident #41's blood pressures were checked prior to the administration of Lisinopril, LPN #2 stated that she wouldn't know. When asked if she checks Resident #41's blood pressure prior to the administration of Lisinopril, LPN #2 did not answer. When asked if the order was followed, LPN #2 stated that the above order was not	F 684		

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F 684	Continued From page 47 followed. When asked if it was possible that Resident #41's received Lisinopril unnecessarily, as the staff did not check the blood pressure, LPN #2 agreed that it was possible. On 8/30/18 at 12:25 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the Quality Assurance Consultant was made aware of the above concerns. The facility policy titled "Medication and Treatment Administration Guidelines" documents in part, the following: "Medications are administered in accordance with professional standards of practice and state specific and federal guidelines." No further information was presented prior to exit. In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary." (1) Lisinopril is used to treat high blood pressure and heart failure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010968/?report=details. (2) Systolic blood pressure "is the pressure caused by your heart contracting and pushing out blood. Normal blood pressure for adults is	F 684		

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F 684	Continued From page 48 defined as a systolic pressure of less than 120." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/health/high-blood-pressure.	F 684	**F693** The statement made of this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to provide treatment and services for the management of tube feeding. **I. Corrective Action** Upon notification by the surveyor that Resident #35's HOB was not elevated, resident was assessed with no findings and nurse and CNA were re-educated on ensuring that resident's HOB is elevated per resident's POC. **II. Identification** All residents receiving enteral therapy in the facility have the potential to be affected by the alleged deficient practice.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide treatment and services for the management of a tube feeding for one of 30 residents in the survey sample, Resident #35.	F 693		

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F 693	Continued From page 49 The facility staff failed to elevate the head of Resident #35's bed 30-45 degrees 1 hour post feeding per the plan of care to prevent complications of enteral feeding. The findings include: Resident #35 was admitted to the facility on 4/2/2009 and readmitted on 7/29/2014 with diagnoses that included but were not limited to cerebrovascular disease (stroke), dysphagia (difficulty swallowing with NPO (nothing by mouth) status, and vascular dementia. Resident #35's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/11/18. Resident #35 was coded as severely impaired in cognitive function scoring 02 out of possible 15 on the BIMS (brief interview for mental status exam). Resident #35 was coded as requiring total dependence on two of more staff with eating, locomotion, toileting, bathing, and personal hygiene; and extensive assistance from staff with transfers. Resident #35 was coded in Section K (Swallowing/Nutritional Status) as having a feeding tube in place. Review of Resident #35's August 2018 POS (physician order summary) documented the following order: "Jevity 1.2 at 84 ml (milliliters) an hour. Start at 4 p.m. and run until 1176 mls have infused via gast (gastronomy tube) (1)." Review of Resident #35's comprehensive care plan dated 7/20/18 documented the following: "Need for feeding tube r/t (related to) dysphagia with NPO (nothing by mouth) status...Interventions: elevate the head of bed	F 693	**III. Systemic Changes** Nursing will be re-educated on elevating the HOB for residents receiving TF per MD order and plan of care. **IV. Monitoring** DON and/or designee will visually observe (5) residents on receiving TF to ensure that they are that HOB is elevated per MD order. These audits will be done weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need audits and/or actions. **V. Date of Compliance** 10/04/2018	

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F 693	Continued From page 50 30-45 degrees during and 1 hour post feeding." On 8/29/18 at 7:45 a.m., an observation was made of Resident #35. Her tube feed on was on a running at 84 ml/hr. Her head of bed was elevated at least 30 degrees. On 8/29/18 from 8:00 a.m. until 8:10 a.m., medication pass was observed with Resident #35's nurse, who was also the only medication nurse on the unit. On 8/29/18 at 8:22 a.m., this writer knocked on Resident #35's door. The aide (CNA [certified nursing assistant]) #2 stated that she was providing care to Resident #35. On 8/29/18 at 8:37 a.m., an observation was made of Resident #35. Her tube feed equipment had been disconnected and removed from her room. Resident #35's head of bed was completely flat. It had not been 1 hour since the tube feeding was last observed up and running. On 8/29/18 at 8:49 a.m., Resident #35's head of bed continued to be completely flat. On 8/29/18 at 9:28 a.m., Resident #35 was observed up in her reclining chair. On 8/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #35's nurse. LPN #2 was asked when she took down Resident #35's tube feed on 8/29/18. LPN #2 stated she could not remember but that it was when she gave Resident #35 her morning medications and before the aide provided ADL (activities of daily living) care. LPN #2 was asked how the head of bed should be	F 693		

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F 693	Continued From page 51 elevated for residents with a tube feed during the feeding and immediately post feeding. LPN #2 stated the head of bed should be elevated 35-40 degrees. When asked why it was important for residents with tube feedings to have the head of bed elevated post feeding, LPN #2 stated that the resident could aspirate. LPN #2 stated the head of bed should never be flat immediately post tube feeding. When asked if she had noticed that Resident #35's head of bed was completely flat yesterday within the one hour post feeding window, LPN #2 stated that she was not aware of this. LPN #2 confirmed that Resident #35's care plan instructed the nursing staff to keep the head of bed elevated to 30-45 degrees one hour post feeding. LPN #2 stated that all nursing staff had access to the care plan. This writer informed LPN #2 of the above observations. LPN #2 confirmed that the care plan was not followed if it was observed that Resident #35's head of bed was completely flat. CNA #2 could not be reached for an interview. On 8/30/18 at 12:25 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the Quality Assurance Consultant was made aware of the above concerns. A request was made to speak to any CNA from the nursing unit. On 8/30/18 at 12:52 p.m., an interview was conducted with CNA #1. When asked about the process followed by staff when providing ADL care to a resident with a tube feed, CNA #1 stated that she would call the nurse to unplug the feeding so that it is out of the way. CNA #1 stated that she would lower the head of bed to provide care, but not all the way down as the resident	F 693		

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F 693	Continued From page 52 could aspirate. CNA #1 stated that immediately after care she would raise the head of bed back up and then call the nurse to restart the feeding. On 8/30/18 at approximately 1 p.m., ASM #2 brought in the facility's enteral feed policy. ASM #2 pointed out that the policy documented that the head of bed should be elevated for a minimum of 30 minutes after feedings are completed. When asked if she expected her staff to follow the facility policy or resident care plan, ASM #2 stated that she did not realize Resident #35's care plan documented an hour and that the care plan should be followed. No further information was presented prior to exit. (1) Gastronomy tube- "Gastrostomy (PEG) is the preferred route of feeding and nutritional support in patients with a functional gastrointestinal system who require long-term enteral nutrition. The primary indication for enteral and parenteral feeding is the provision of nutritional support to meet metabolic requirements for patients with inadequate oral intake." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4069302/	F 693	**F695** The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to provide respiratory care and services.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695	**I. Corrective Action** Resident #11's oxygen is now being administered per MD's order.	

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F 695	Continued From page 53 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to provide respiratory care and services for one of 30 residents in the survey sample, Resident # 11. The facility staff failed to administer Resident # 11's oxygen according to the physician's orders. The findings include: Resident # 11 was admitted to the facility on 02/28/18 and a readmission of 07/07/18 with diagnoses that included but were not limited to respiratory failure, (1), anemia, (2), depressive disorder (3), and diabetes mellitus (4). Resident # 11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/07/18, coded Resident # 11 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Under section "O. Special Treatment, Procedures and Programs" Resident # 69 was coded for "C. Oxygen therapy." On 08/28/18 at 1:21 p.m., an observation of Resident # 11 revealed she was dressed, sitting in her wheelchair watching television, receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen flow meter on the oxygen concentrator revealed the oxygen flow rate between two and a half and	F 695	**II. Identification** All residents receiving oxygen therapy have the potential to be affected. **III. Systemic Changes** Nursing staff have been re-educated on administration of oxygen at the prescribed rate. **IV. Monitoring** DON and/or designee will audit five (5) residents receiving respiratory care to ensure that oxygen is being administered at prescribed rate weekly x four and then monthly x two. The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions. **V. Date of Compliance** 10/04/2018	

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F 695	Continued From page 54 three liters per minute. On 08/28/18 at 2:30 p.m., an observation of Resident # 11 revealed she was sitting in her wheelchair watching television, receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen flow meter on the oxygen concentrator revealed oxygen flow rate between two and a half and three liters per minute. On 08/28/18 at 4:30 p.m., an observation of Resident # 11 revealed her sitting in her wheelchair watching television, receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen flow meter on the oxygen concentrator revealed oxygen flow rate at two liters per minute. The POS (physician's order sheet) for Resident # 11 dated "August 2018"documented, "07/07/18 Oxygen at 2l/M (two liters per minute) via (by) nasal cannula continuously." The comprehensive care plan for Resident # 11 dated 07/08/2018 documented, "Focus. Has/At risk for respiratory impairment related to COPD (chronic obstructive pulmonary disease." Under "Interventions" it documented, "Administer oxygen per MD (medical doctor) orders. Date initiated: 07/09/2018." On 08/28/18 at 4:30 p.m., an interview was conducted with Resident # 11. When asked if she adjusted her oxygen Resident # 11 stated, "No, a lady came in with my nurse and they did something." On 08/29/18 at 11:45 a.m., an interview was	F 695		

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MANORCARE HEALTH SERVICES-ALEXANDRIA	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(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 695	Continued From page 55 conducted with ASM (administrative staff member) # 3, quality assurance consultant. When asked if she entered Resident # 11's room the previous day, on 08/28/18, with Resident # 11's nurse ASM # 3 stated, "Yes. I checked the oxygen with (LPN [licensed practical nurse] # 2)." On 08/29/18 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked if she entered Resident # 11's room the previous day, on 08/28/18 LPN # 2 stated, "Yes I adjusted the oxygen because it was supposed to be at two liters and it was at two and a half. When asked how often a resident's oxygen is check LPN # stated, "I check it when I do rounds, every two hours." On 08/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked to describe how to read the flow rate of a resident's oxygen LPN # stated, "Knee down and get eye level with the concentrator, the liter line should be through the middle of the ball." On 08/30/18 at approximately 12:25 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.	F 695		

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F 695	Continued From page 56 (2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . (3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 695	**F697** The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 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 provide a complete pain assessment and attempt non-pharmacological interventions for three of 30 residents in the survey sample, Residents # 11, # 41 and # 2.	F 697	It is the practice of the facility to provide a comprehensive pain management program and services. **I. Corrective Action** Resident #11's nurse was re-educated on completely assessing pain and offering non-pharmacological intervention prior. Resident #41's nurse was re-educated on completely assessing pain and offer non-pharmacological intervention prior.	

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F 697	Continued From page 57 1a. The facility staff failed to document the location of pain prior to the administration of Resident # 11's prn (as needed) pain medication. 1b. The facility staff failed to implement non-pharmacological interventions prior to the administration of Resident # 11's prn (as needed) pain medication. 2. The facility staff failed to document a complete pain assessment and failed to attempt non-pharmacological interventions prior to the administration of Tramadol to Resident #41, on several occasions in July and August of 2018. 3. The facility staff failed to document a complete pain assessment and attempt non-pharmacological interventions prior to the administration of Ibuprofen to Resident #2, on four occasions in July and August of 2018. The findings include: 1a. The facility staff failed to document the location of pain prior to the administration of Resident # 11's prn (as needed) pain medication of MAPAP [Tylenol] (1) and Tramadol (2). Resident # 11 was admitted to the facility on 02/28/18 and a readmission of 07/07/18 with diagnoses that included but were not limited to respiratory failure, (3), anemia, (4), depressive disorder (5), and diabetes mellitus (6). Resident # 11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/07/18, coded Resident # 11 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0	F 697	Resident #2's nurse was re-educated on offering non-pharmacological intervention prior to administration of as needed medication. **II. Identification** All residents receiving pain medication have the potential to be affected. **III. Systemic Changes** Licensed nurses have been re-educated completing assessment per pain policy. **IV. Monitoring** DON and/or designee will complete random audits of five (5) residents chart to ensure that pain assessment was completed and non-pharmacological intervention attempted prior to administration of as needed pain medication. These audits will be done weekly x four (4) and monthly x two (2).The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions.	

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F 697	Continued From page 58 - 15, 15 - being cognitively intact for making daily decisions. Resident # 11 was coded as requiring limited to extensive assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 69 was coded for "C. Oxygen therapy." The POS (physician's order sheet) for Resident # 11 dated "August 2018" documented, "MAPAP 325MG (milligram) [Tylenol]. 2 (two) tabs (tablets) by mouth every day as needed for Pain - max (maximum) acetaminophen 3-4 GM (grams) daily - check daily total. 07/07/2018." "Tramadol 50 MG (milligram) tablet. 1 (one) tab (tablet) by mouth every 6 (six) hours as needed for pain. 07/07/2018" The MAR (medication administration record) for Resident # 11, dated "August 2018" documented the above physician's orders. The August 2018 MAR failed to evidence the administration of MAPAP. Further review of the August MAR revealed Tramadol 50 MG was administered to Resident #11, on 08/01/18, 08/06/18, 08/12/18 and 08/14/18. Further review of the MAR failed to evidence documentation of Resident # 11's location of pain. Review of "Progress Notes" for Resident # 11 dated 08/01/18 through 08/29/18 failed to evidence documentation of Resident # 11's pain location prior to the administration of prn Tramadol on 08/01/18, 08/06/18, 08/12/18 and 08/14/18. On 08/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) # 2.	F 697	V. Date of Compliance 10/04/2018	

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F 697	Continued From page 59 LPN # 2 was asked to describe the procedure staff follows for the administration of prn (as needed) pain medications. LPN # 2 stated, "Asked the patient the level of pain 1-10 ten being worse, where the pain is, when it started. Go to the MAR and check the prn pain medication that they can have, give the one I'm supposed to give, go back and check them after 30 min to see if the medication worked and get another pain level. After I give it, I document on the back of the MAR the time, the date, my initials, type of pain medication, pain level, and document in the nurse's notes the time it was given, type of medication and amount." When asked if the resident's location of their pain is documented, LPN # 2 stated, "Yes, in the nurse's notes." LPN # 2 was asked to review the August MAR dated 2018 and the Progress Notes" dated 08/01/18 through 08/29/18 for Resident # 11. When asked if the location of Resident # 11's pain was documented, LPN # 2 stated, "No." When asked if a complete pain assessment was completed for Resident # 11, LPN # 2 stated, "No." On 08/30/18 at approximately 12:25 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit. References: (1) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the	F 697		

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F 697	Continued From page 60 pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html. (2) Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html. (3) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (4) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html. (5) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger,	F 697		

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F 697	Continued From page 61 or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (6) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 1b. The facility staff failed to implement non-pharmacological interventions prior to the administration of Resident # 11's prn (as needed) pain medication. The POS (physician's order sheet) for Resident # 11 dated "August 2018" documented, "MAPAP 325MG (milligram) [Tylenol]. 2 (two) tabs (tablets) by mouth every day as needed for Pain - max (maximum) acetaminophen 3-4 GM (grams) daily - check daily total. 07/07/2018." "Tramadol 50 MG (milligram) tablet. 1 (one) tab (tablet) by mouth every 6 (six) hours as needed for pain. 07/07/2018" The MAR (medication administration record) for Resident # 11, dated "August 2018" documented the above physician's orders. The August 2018 MAR failed to evidence the administration of MAPAP. Further review of the August MAR revealed Tramadol 50 MG was administered to Resident #11, on 08/01/18, 08/06/18, 08/12/18 and 08/14/18. Further review of the MAR failed to evidence documentation of non-pharmacological interventions prior to the administration of Resident # 11's prn (as needed) pain medication.	F 697		

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F 697	Continued From page 62 Review of "Progress Notes" for Resident # 11 dated 08/01/18 through 08/29/18 failed to evidence documentation of non-pharmacological interventions prior to the administration of Resident # 11's as needed Tramadol on 08/01/18, 08/06/18, and 08/12/18 and on 08/14/18. The comprehensive care plan for Resident # 11 dated 07/08/2018 documented, "Focus. At risk for pain related to immobility, gout, neuropathy." Under "Interventions" it documented, "Implement non-pharmacological interventions such as music, watching TV or positioning to assist with pain and monitor for effectiveness. Date initiated: 07/09/2018." On 08/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked to describe the procedure staff follow for the implementation of non-pharmacological interventions prior to the administration of prn (as needed) pain medications, LPN # 2 stated, "Non-pharmacological interventions should it be attempted prior to giving the pain medication." When asked where it is documented that the non-pharmacological interventions were attempted, LPN # 2 stated, "In the progress notes." LPN # 2 was asked to review the August MAR and progress notes dated for Resident # 11 dated 08/01/18 through 08/29/18. When asked if there was documentation that non-pharmacological interventions were attempted when Resident # 11 was administered Tramadol on 08/01/18, 08/06/18, 08/12/18 and on 08/14/18, LPN # 2 stated no. When asked if there was no documentation of non-pharmacological interventions, being attempted could you say it was done, LPN # 2	F 697		

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F 697	Continued From page 63 stated no. On 08/30/18 at approximately 12:25 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit. References: (1) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html. (2) Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.	F 697		

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F 697	Continued From page 64 2. The facility staff failed to document a complete pain assessment and failed to attempt non-pharmacological interventions prior to the administration of Tramadol to Resident #41, on several occasions in July and August of 2018. Resident #41 was admitted to the facility on 7/13/18 with diagnoses that included but were not limited to muscle weakness, high blood pressure, and atrial fibrillation. Resident #41's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/20/18. Resident #41 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #41's July and August 2018 POS (physician order summary) revealed the following order: "Tramadol 50 mg (milligrams) 1 tab (tablet) by mouth every 8 hours as needed for pain." Review of Resident #41's July 2018 MAR (medication administration record) revealed that Resident #41 received Tramadol on the following dates: 7/18/18 at 1 p.m., 7/19/18 at 9 a.m., 7/20/18 at 9 a.m., 7/23/18 at 9:00 a.m., 7/24/18 at 8:00 a.m., and 7/27/18 at 10:00 p.m. On 7/27/18, there was no pain scale, follow up pain scale/evaluation or location of pain documented on the back of the MAR. There was no evidence that non-pharmacological pain relief interventions were attempted prior to the administration of Tramadol for all above dates. Review of Resident #41's July nursing notes	F 697		

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F 697	Continued From page 65 failed to evidence that non-pharmacological pain interventions were attempted prior to the administration of Tramadol on the above dates. There were no nursing notes that addressed Resident #41's pain on 7/27/18. Review of Resident #41's August 2018 MAR (medication administration record) revealed that Resident #41 received Tramadol on the following dates: 8/6/18, 8/8/18, 8/11/18, 8/18/18, 8/20/18, 8/22/18, and 8/28/18 On 8/8/18, 8/11/18, 8/18/18 and 8/22/18 there was no evidence of the location of pain documented on the back of the August MAR. There was no documented evidence that non-pharmacological pain relief interventions were attempted prior to the administration of Tramadol for all above dates. August nursing notes could not be found in the clinical record regarding Resident #41's pain for the above dates. Review of Resident #41's pain care plan dated 7/13/18 documented the following intervention: "Implement non-pharmacological interventions such as music, positioning, or OOB (out of bed) to motorized wheelchair to assist with pain and monitor for effectiveness." On 8/29/18 at 9:57 a.m., an interview was conducted with Resident #41. When asked if staff tried other things such a hot therapy, massage etc. prior to giving a pm pain medication, Resident #41 stated that she was just given a pill. On 8/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #41's nurse. When asked about the	F 697		

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F 697	Continued From page 66 process staff follows when administering prn (as needed) pain medications, LPN #2 stated that nurses should be asking the patient their level of pain on a scale from 1-10 (10 being the worst possible pain), and then go check the prn (as needed) pain medications. LPN #2 stated that she would ask the pain level, when it started, and see what pain medications she can give. LPN #2 stated that once pain medication is administered, she would go back and reassess pain after 30 minutes. LPN #2 stated that this information should be documented on the back of the MAR. When asked what was documented on the back of the MAR, LPN #2 stated, "Time, date, my initials, type of medication, pain level." When asked if location of pain was part of the pain assessment, LPN #2 confirmed that it was and that location of pain should be documented. LPN #2 stated that if the pain assessment was not on the back of the MAR, that it may be documented in a nursing note. When asked if other interventions for pain relief should be attempted, prior to administering pain medications, LPN #2 stated that she would attempt sometimes. LPN #2 stated that you could tell by talking to the resident if non-pharmacological pain relief interventions would work. LPN #2 stated that the resident may also refuse. When asked if non-pharmacological interventions should be at least offered prior to giving prn pain medications, LPN #2 stated, "Yes, it should be done each time before giving medication." When asked if it was documented anywhere in the clinical record that non-pharmacological interventions were attempted or offered, LPN #2 stated that that information should be documented in a progress note. When asked why it was important to attempt non-pharmacological pain relief interventions prior to administering pain	F 697		

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	495011	A. BUILDING _____ B. WING _____	C 08/30/2018

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F 697	Continued From page 67 medications, LPN #2 stated that the pain could be managed by other means. LPN #2 confirmed the above concerns. LPN #2 stated that Resident #41 requested her pain medication and that the resident knew what she wanted. When asked again if non-pharmacological interventions should be offered or attempted before any prn, pain medication is given, LPN #2 stated yes. On 8/30/18 at 12:25 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the Quality Assurance Consultant was made aware of the above concerns. (1) Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197. 3. The facility staff failed to document a complete pain assessment and attempt non-pharmacological interventions prior to the administration of Ibuprofen to Resident #2, on four occasions in July and August of 2018. Resident #2 was admitted to the facility on 5/17/18 with diagnoses that included but were not limited to type two diabetes mellitus, hypothyroidism, post stroke, and back pain with spinal stenosis. Resident #2's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/24/18. Resident #2 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #2's was coded as requiring limited assistance from	F 697		

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F 697	Continued From page 68 one staff member with locomotion on and off the unit; extensive assistance with one staff member with transfers, personal hygiene, and bathing; and total dependence on staff with dressing. Review of Resident #2's July and August 2018 POS (physician order summary) documented the following order: "Ibuprofen 200 mg (milligrams), take two tablets po (by mouth) q (every) 8 hours prn (as needed) headache." Review of Resident #2's July and August 2018 MAR (medication administration record) revealed that she received Ibuprofen on the following dates and times: 7/25/18 at 3:00 p.m. and 7/31/18 at 12:00 p.m., 8/3/18 at 1:00 a.m., and 8/25/18 at 3:30 a.m. Review of the July and August 2018 MARS failed to evidence pain scales for the above dates follow up pain assessments and non-pharmacological interventions attempted prior to the administration of Ibuprofen. Review of Resident #2's nursing notes revealed a note dated 8/25/18 that documented in part, the following: "Resident c/o (complaints) pain 3/10. Ibuprofen administered 400 mg resulting in pain 0/10..." This note did not address non-pharmacological interventions attempted prior to the administration of the Ibuprofen. No other notes could be found in the clinical record regarding Resident #2's pain on the above dates. Resident #2's pain care plan dated 5/17/18 documented the following intervention: "Implement non-pharmacological interventions	F 697		

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F 697	Continued From page 69 such as music, positioning or other activities of choice to assist with pain and monitor for effectiveness." On 8/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #41's nurse. When asked about the process staff follows when administering prn (as needed) pain medications, LPN #2 stated that nurses should be asking the patient their level of pain on a scale from 1-10 (10 being the worst possible pain), and then go check the prn (as needed) pain medications. LPN #2 stated that she would ask the pain level, when it started, and see what pain medications she can give. LPN #2 stated that once pain medication is administered, she would go back and reassess pain after 30 minutes. LPN #2 stated that this information should be documented on the back of the MAR. When asked what was documented on the back of the MAR, LPN #2 stated, "Time, date, my initials, type of medication, pain level." When asked if location of pain was part of the pain assessment, LPN #2 confirmed that it was and that location of pain should be documented. LPN #2 stated that if the pain assessment was not on the back of the MAR, that it may be documented in a nursing note. When asked if other interventions for pain relief should be attempted, prior to administering pain medications, LPN #2 stated that she would attempt sometimes. LPN #2 stated that you could tell by talking to the resident if non-pharmacological pain relief interventions would work. LPN #2 stated that the resident may also refuse. When asked if non-pharmacological interventions should be at least offered prior to giving prn pain medications, LPN #2 stated, "Yes, it should be done each time before giving medication." When asked if it was	F 697		

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F 697	Continued From page 70 documented anywhere in the clinical record that non-pharmacological interventions were attempted or offered, LPN #2 stated that that information should be documented in a progress note. When asked why it was important to attempt non-pharmacological pain relief interventions prior to administering pain medications, LPN #2 stated that the pain could be managed by other means. LPN #2 confirmed the above concerns. On 8/30/18 at 12:25 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the Quality Assurance Consultant was made aware of the above concerns. (1) Ibuprofen is a non-steroidal anti-inflammatory drug used to treat mild to moderate pain. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010648/?report=details.	F 697	F757 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to ensure that residents are free of unnecessary medication.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757	**I. Corrective Action** Resident #41's doctor was called and notified that BP not obtained per MD's order. **II. Identification** Residents who has parameters for medication administration.	

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F 757	Continued From page 71 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 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 facility staff failed to ensure a resident was free from unnecessary medications for one of 30 residents in the survey sample, Resident #41. The facility staff administered Lisinopril (blood pressure medication) (1) without checking Resident #41's blood pressure per physician's order on several occasions (22 times) in August 2018. The findings include: Resident #41 was admitted to the facility on 7/13/18 with diagnoses that included but were not limited to muscle weakness, high blood pressure, and atrial fibrillation. Resident #41's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/20/18. Resident #41 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.	F 757	**III. Systemic Changes** Licensed nurses were re-educated to administer medication per MD order. **IV. Monitoring** DON and/or designee will complete audit of five residents with medication parameters to ensure BP are obtained and medication administer as ordered weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action will be taken as appropriate. The committee will determine need for further audits and/or actions. **V. Date of Compliance** 10/04/2018	

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F 757	Continued From page 72 Review of Resident #41's most recent POS (physician order summary) signed by the physician on 8/6/18, revealed the following order: "Lisinopril 25 mg (milligrams) po (by mouth) qd (every day) for HTN (high blood pressure), Hold for SBP (systolic blood pressure) (2) less than 120." This order was initiated on 8/1/18. Review of Resident #41's August 2018 MAR (medication administration record) revealed Lisinopril was administered 8/1/18 through 8/29/18. There was no evidence of documented blood pressures on the MAR. Review of the vital sign tab on PCC (point click care) in the electronic record, revealed blood pressures were obtained and documented on the following dates: 8/1/18, 8/2/18, 8/3/18, 8/5/18, 8/12/18, 8/19/18, and 8/26/18. There was no evidence of blood pressures for the remaining 22 days in the clinical record. Resident #41's cardiac care plan dated 7/17/18 documented in part, the following: "Cardiac disease related to Hypertension Goal: Will experience effective symptom management over the quarter. Interventions: Administer medication per physician's order." On 8/29/18 at 9:57 a.m., an interview was conducted with Resident #41. When asked how often her blood pressure was checked, Resident #41 stated that she barely gets her blood pressure checked and was not sure if it was supposed to be more frequent. On 8/30/18 at 11:27 a.m., an interview was conducted with LPN (licensed practical nurse) #2,	F 757		

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F 757	Continued From page 73 Resident #41's nurse. When asked about the process staff follows when a resident has physician ordered parameters for blood pressure medication, LPN #2 stated that nursing should check the resident's blood pressure, and if the blood pressure is out of range for the medication to be administered, then the medication should be held. LPN #2 stated, "The physician also needs to be made aware if the blood pressure medication is held." LPN #2 confirmed that blood pressure should be checked every time prior to administering blood pressure medications with parameters. When asked where blood pressures were documented, LPN #2 stated that blood pressure should be documented on the MAR. When asked if Resident #41's blood pressures were documented on her MAR, LPN #2 confirmed that blood pressures were missing. LPN #2 stated that blood pressures may have been documented in the nursing notes. This writer showed LPN #2 Resident #41 is nursing notes. LPN #2 confirmed that blood pressures for the missing dates were not documented. When asked how she would know that Resident #41's blood pressures were checked prior to the administration of Lisinopril, LPN #2 stated that she wouldn't know. When asked if she checks Resident #41's blood pressure prior to the administration of Lisinopril, LPN #2 did not answer. When asked if the order was followed, LPN #2 stated that the above order was not followed. When asked if it was possible that Resident #41's received Lisinopril unnecessarily, as the staff did not check the blood pressure, LPN #2 agreed that it was possible. On 8/30/18 at 12:25 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the	F 757		

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F 757	Continued From page 74 Quality Assurance Consultant was made aware of the above concerns. A policy could not be provided regarding the above concerns. (1) Lisinopril is used to treat high blood pressure and heart failure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010968/?report=details. (2) Systolic blood pressure "is the pressure caused by your heart contracting and pushing out blood. Normal blood pressure for adults is defined as a systolic pressure of less than 120." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/health/high-blood-pressure.	F 757		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812	F812 The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to Serve and store food in a sanitary manner.	

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F 812	Continued From page 75 from consuming foods not procured by the facility. §483.60(l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. 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 serve and store food in a sanitary manner. The facility staff failed to ensure a food processor, clean and ready for use was free of standing water inside the bowl and failed to ensure a bowl of chopped garlic was covered while being stored in the walk-in refrigerator. The findings include: On 08/28/18 at approximately 10:55 a.m., an observation of the kitchen was conducted with OSM (other staff member) # 4, dietary manager. An observation of the food processor revealed it was assembled, sitting on the kitchen preparation table. When asked if the food processor was cleaned and ready for use OSM # 4 stated yes. Upon opening the top of the food processor, bowl an observation of the inside of the bowl revealed water in the bottom of the bowl. When OSM # 4 was asked to estimate the amount of water in the bowl, OSM # 4 stated, "Looks like a couple of table spoons." OSM # 4 immediately removed all the parts of the food processor and sent them to the sink to be washed. An observation of the walk-in refrigerator with OSM # 4 revealed an uncovered Styrofoam bowl	F 812	**I. Corrective Action** OSM #4 was immediately re-educated on serving and storing food sanitary manner. The food processor was cleaned and garlic was discarded. **II. Identification** All residents in the facility have the potential to be affected by the alleged deficient practice. **III. Systemic Changes** Dietary staff will be re-educated on serving and storing food in a sanitary manner. **IV. Monitoring** Food Service Director and/or designee will observe food storage to ensure food is served and stored in sanitary manner weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine the need for further audits and/or actions.	

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F 812	Continued From page 76 on a shelf containing approximately half a cup of chopped garlic. OSM # 4 stated, "This should be covered" and immediately removed it from the walk-in refrigerator and threw it away. The facility's policy "Cleaning Procedure-Blender/Food Process" documented, "6. Air dry." The facility's policy "Storage of Food" documented in part, "6. Store food stock and products in National Sanitation Foundation approved sanitary storage containers with lids or in food quality plastic bags, and label as to contents and date where appropriate." On 08/29/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit.	F 812	**V. Date of Compliance** 10/04/18	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842	**F 842** The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to Ensure accurate and complete resident records.	

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F 842	Continued From page 77 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842	**I. Corrective Action** Resident #13's kardex was immediately updated to reflect resident code status. **II. Identification** All residents residing in the facility have the potential to be affected by the alleged deficient practice. **III. Systemic Changes** Licensed nurses were re-educated on timely updating resident's kardex with new information. House audit was completed to ensure consistency of code documentation. **IV. Monitoring** DON and/or designee will complete audit of five residents kardex to ensure it has been updated with new information weekly x four (4) and then monthly x two (2). The results of these audits will be forwarded to the Quality Assurance and Assessment Committee for review and action as appropriate. The committee will determine need for further audits and/or actions.	

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MANORCARE HEALTH SERVICES-ALEXANDRIA	1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308

(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 842	Continued From page 78 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 30 residents in the survey sample, Resident #13. The facility staff failed to ensure the "Do Not Resuscitate" (DNR) status of Resident #13 was accurately entered into the Task/Kardex section of the electronic medical record. The findings include: Resident #13 was admitted to the facility on 1/2/15 with diagnoses that included but were not limited to: Alzheimer's disease, difficulty swallowing, adult failure to thrive (weight loss, muscle wasting, weakness) (1), and contractures (A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement) (2) of the hands.	F 842	V. Date of Compliance 10/04/2018	

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F 842	Continued From page 79 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/10/18, coded the resident as having no ability in making self-understood by others, as well as rarely/never understanding others. The resident was coded as requiring total assistance of at least one or more staff members for bed mobility, transfers, locomotion on and off the unit, dressing, eating, toileting, bathing, and personal hygiene. In Section O - Special Treatments, Procedures and Programs, the resident was coded as requiring hospice care during the look back period. A review of Resident #13's clinical record revealed physicians order date of order documenting, "Do Not Resuscitate-Do Not Transfer-Hospice." A review of Resident #13's clinical record documented the "Durable Do Not Resuscitate Order" that was signed by Resident #13's responsible representative on 2/12/18. A review of the comprehensive care plan dated 9/4/17, with a most recent revision on 3/27/18, documented in part, "Focus: Hospice care need due to senile degeneration of the brain". The Interventions section of this focus documented in part, "Honor advanced directives (legal documents that allow you to spell out your decisions about end-of-life care ahead of time)." A review of the electronic medical record under the "Tasks-Visual/Bedside Kardex Report" section, documented in part, "Code Status: Full Code."	F 842		

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F 842	Continued From page 80 On 08/30/18 at 11:23 a.m., RN (registered nurse) #3 was asked how the staff is made aware of a resident's code status. RN #3 stated that all of the "DNR" (do not resuscitate) residents' charts are marked with a red name label. In addition, in the front of the resident's clinical record, an alert is copied onto red paper stating that the resident is a DNR. Behind this red DNR sheet is the signed and dated "Durable Do Not Resuscitate Order". RN #3 was asked if this information regarding a resident's code status was in the Task/Kardex section of the electronic clinical record, RN #3 stated she did not know. At that time, RN #3 reviewed the electronic medical record of Resident #13. She then verified that the documentation in the Task/Kardex section documented that Resident #13 was noted to be a full code. RN #3 fixed this immediately by updating Resident #13's Task/Kardex to reflect the correct code status as a DNR, after confirming this per the advanced directive on the Resident's clinical record. RN #3 stated that this must be a "system generated issue" as Point Click Care (PCC) (the electronic medical record system the facility uses) was recently updated. RN #3 stated she was told that all of each resident's information would be transferred over automatically during the system update. RN #3 began randomly checking known DNR residents to see if their records were also inaccurate. During this random check, she noted several inaccuracies regarding the residents' code status. She stated she would do a full check on all DNR residents to ensure this information is correctly entered. On 8/30/18 at 11:33 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing, and ASM #4,	F 842		

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F 842	Continued From page 81 the quality assurance consultant. They were asked when the most recent upgrade PCC upgrade was performed. ASM #2 and ASM #3 stated it was performed on 6/4/18. ASM #2 and ASM #3 were then asked to describe the process when a resident codes (without breathing and heartbeat). They stated whoever observes a resident without a heartbeat and breathlessness, will call a code "blue". At that time, staff will check the resident's chart to verify the resident's advanced directive and code status. Staff will then communicate this information to the staff in the resident's room whether the resident is a DNR or a Full Code (indicating that the resident wants full resuscitative measure performed). When asked about the process staff follows if the resident's code status has not yet been determined by the resident or the responsible party, ASM #2 stated, "We treat them as a full code until we have documentation indicating that they [the resident] wants to be a DNR." When asked if the Task/Kardex section of the record is used to make the final decision to provide live saving services to a resident, ASM #2 stated, "No, the kardex is not the only code status identifier. It is mainly a "for your information" documentation for the CNAs (certified nursing assistants." When asked if the code status should be documented accurately in all documentation pertaining to a resident, ASM #2 and ASM #3 stated, "Yes." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance consultant, where made aware of the above concerns on 8/30/18 at 11:45 a.m. The facility staff was asked to provide their policy	F 842		

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F 842	Continued From page 82 regarding advanced directives. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000299.htm 2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003185.htm 3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/advancedirectives.html	F 842		