STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	An unannounced Medicare/Medicaid standard survey was conducted 5/23/17 through 5/25/17. 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 124 bed certified facility was 118 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #1 through #21) and five closed record reviews (Residents #22 through #26).			
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (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 -	F 279		7/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/16/2017

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F 279	Continued From page 1 (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 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 staff interview and clinical record review, it was determined that the facility staff	F 279	The Laurels of Bon Air wishes to have this submitted plan of correction stand as	

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F 279	Continued From page 2 failed to develop a comprehensive care plan for one of 26 residents in the survey sample, Resident #2. The facility staff failed to develop a care plan for the CAA (care area assessment) - triggered area of psychotropic drug use. This area was triggered on the 3/2/17 admission MDS (minimum data set). The findings include: Resident #2 was admitted to the facility on 2/23/17 with diagnoses including, but not limited to: multiple sclerosis (1), dementia, and history of a stroke. On the most recent MDS (minimum data set), a 14-day Medicare assessment with the assessment reference date of 3/10/17, Resident #2 was coded as being independent with making daily decisions. He was coded as receiving psychoactive medications on all seven days of the look back period. A review of the admission MDS with an assessment reference date of 3/2/17 revealed that the CAA (care area assessment) in section V triggered psychoactive medications as an area to be addressed in the comprehensive care plan. The box indicating whether or not the CAA trigger was to be care planned had a check mark in it. A review of Resident #13's comprehensive care plan dated 3/9/17 failed to reveal goals or interventions related to psychoactive medication use. On 5/24/17 at 5:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional QA	F 279	its allegation of compliance. Our date of alleged compliance is July 8, 2017. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F Tag 279: Care plans for residents #2 and #13 have been corrected to reflect goals and interventions in regards to psychotropic drug use. All residents prescribed psychotropic medications have the potential to be affected. The Regional MDS nurse will educate MDS nurses and Social Services on completion of care plans, specifically items triggered in the psychosocial CAA. The MDS nurses and Social Services will complete a 100% audit of all residents currently on psychotropic medications to ensure CAA's and care plans are in place. Any variances will be corrected and continued education provided. The MDS nurse/designee will review all new admissions admitted on a	

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F 279	Continued From page 3 (quality assurance) manager, were informed of these concerns. Policies regarding care plan development for triggered CAAs on MDS assessments were requested. On 5/25/17 at 9:45 a.m., ASM #3 stated she had not located a policy related to developing care plans, but she was still looking. On 5/25/17 at 9:00 a.m., OSM (other staff member) #9, the social worker, was interviewed. She stated she is the staff member usually responsible for developing care plans from the CAAs for psychoactive medications. She stated that when the MDS is completed, the CAA areas "pop up" and she develops care plans from those areas. When asked about the care plan for psychoactive medications for Resident #2, OSM #9 stated: "It's just an oversight. I can't believe I missed it." No further information was provided prior to exit. According to the CMS RAI (Centers for Medicaid and Medicare Services Resident Assessment Instrument) Version 1.14 (October 2016): "Coding Instructions for V0200A, CAAs ·Facility staff is to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column a "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed	F 279	psychotropic medications for completion of CAA and care plan for the next 4 weeks. Any variances will be corrected and continued education will be provided. A random audit will then be completed monthly for the next 3 months. Results of audits will reported to the DON who will report results to the QA committee. Continued compliance will be monitored through the facilities quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 279	Continued From page 4 instructions on the CAA process, care planning, and documentation. ·For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed." According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 278; "The nurse applies the nursing process to provide appropriate and effective nursing care. The process begins with an assessment or gathering and analysis of information about the client's health status. The nurse then makes clinical judgments about the client's response to health problems, defined as nursing diagnoses. Once the nurse defines appropriate nursing diagnoses, a plan of care is developed. The plan includes interventions individualized to each of the client's nursing diagnoses. The nurse performs all planned interventions in an effort to improve or maintain the client's health. After administering interventions, the nurse evaluates the client's response and whether the interventions were effective."	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development	F 280		7/8/17

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F 280	Continued From page 5 and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans	F 280		

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F 280	Continued From page 6 (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, facility staff	F 280	F Tag 280:	

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F 280	Continued From page 7 failed to review or revise the comprehensive care plan for one of 26 residents in the survey sample, Resident #12. The facility staff failed to review or revise Resident #12's care plan following a fall on 3/21/17. The findings include: Resident #12 was admitted to the facility on 10/5/10 and readmitted on 11/3/16 with diagnoses that included but were not limited to hypertension, dementia without behavioral disturbance, difficulty swallowing, osteoporosis, hip fracture, and stroke. Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/20/17. Resident #12 was documented as being moderately impaired in cognitive function, scoring 07 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring extensive assistance from one staff member with transfers, dressing, toileting, and personal hygiene; total dependence on one staff member with bathing, and supervision only with meals. Review of Resident #12's clinical record revealed the following note dated 3/23/17: T (temperature)- 97.5; P (pulse)- 70; R (respirations)- 18, B/P (Blood pressure) 150/78, Pox (pulse ox)- 96% on 02 @ 2 L/M (liters per minute) via nasal cannula continuously; Guest is on F/U (follow up) for fall with injuries sustained to RT (right) forehead region (small laceration to forehead-same (sic) was steristripped (sic). Area appears slightly discolored; Linear laceration is closed and healing is in progress (sic); Treatment in	F 280	Care plan for resident #12 has been reviewed and revised to reflect goals and interventions appropriate regarding current fall interventions. All current residents who have had a fall have the potential to be affected. The DON/designee will educate all licensed nurses on timely development of a comprehensive care plan to include fall interventions along with the inclusion of the resident and/or resident representative. The administrative nursing team will complete a 100% audit of all resident with a reported fall in the last 60 days to ensure all care plan interventions are accurate. Any variances will be corrected and continued education will be provided. All reported residents with an incident of a fall will be reviewed during the clinical operations meeting held 5x/week to ensure care plan interventions are updated for 4 weeks. A random audit will be completed 2x/month to ensure all interventions relating to falls are accurate. Any variances will be corrected and continued education will be provided. Continued compliance will be monitored through the facilities quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 280	Continued From page 8 progress; PERRLA (pupils equal round, reactive to light and accommodation); moving all extremities as before incident; new order REC'D (recommendation) for left sided safety mat which is insitu (in place)..." Review of Resident #12's safety and fall care plan dated 11/23/16 failed to document the fall mat as an intervention. There was no evidence that the care plan was reviewed or revised. On 5/24/17 at 3 p.m., ASM #3, the Regional QA nurse was asked to go over Resident #12's falls with this surveyor. ASM #3 looked at Resident #12's care plan and stated that she could not find updates after the 3/21/17 fall. On 5/24/17 at 4:42 p.m., an interview was conducted with RN (registered nurse) #1, the unit manager of Grand Summit nursing station. When asked about the process staff follows if a resident has a fall, RN #1 stated that as a nurse she would assess the resident for injury and monitor vital signs. RN #1 stated that she would then fill out an incident report. RN #1 stated that the nurse assigned to the resident is responsible for completing an incident report. RN #1 stated that the MD (medical doctor) and RP (responsible party) should also be notified. RN #1 stated that the nurse should then make a judgement on the best intervention to put into place to prevent future falls. RN #1 stated that the next day, the IDT (interdisciplinary team) will then decide if the intervention is appropriate. RN #1 stated that the IDT team will change interventions if necessary. RN #1 stated that the IDT team included the DON (Director of Nursing), ADON (assistant director of nursing), all unit managers, therapy, and MDS. RN #1 stated that the MDS nurse would be	F 280		

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F 280	Continued From page 9 responsible for updating the care plan with the new intervention or the MDS nurse would be responsible for reviewing the care plan after a fall. RN #1 confirmed that she could not find an intervention for the fall mat on the care plan after Resident #12's fall on 3/21/17. On 5/25/17 at approximately 12:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Regional QA (quality assurance) manager were made aware of the above concerns. The Facility policy titled, "Interdisciplinary Care Plan" documents in part the following: "...4. Care plans are revised as dictated by change(s) in the guest's condition. Reviews are done at least quarterly." According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." No further information was presented prior to exit.	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i)	F 281		7/8/17

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F 281	Continued From page 10 (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 facility staff failed to follow professional standards of practice for two of 26 residents in the survey sample, Residents # 6, 5, and 7. 1. The facility staff failed to clarify Resident #6's physician order for Baclofen [1] 10 mg (milligrams). 2. The facility staff failed to transcribe a physician order as written for Resident #7. The findings include: 1. Resident #6 was admitted to the facility on 1/25/15 with diagnoses that included but were not limited to muscle weakness, paralysis on one side of the body post stroke, history of falls, and difficulty swallowing. Resident #6's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/27/17. Resident #6 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #6's most recently signed	F 281	F Tag 281: Medication orders for residents #6 and #7 have been clarified per physician's orders. All resident receiving medications have the potential to be affected. The DON/designee will educate all licensed nurses on order clarification and correct order entry. All new medication orders to include all new admissions will be reviewed in clinical operations meeting 5x/week for 4 weeks to ensure accuracy in transcription and order entry. Any variances will be corrected and continued education will be provided. Continued compliance will be monitored through the facilities quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 281	Continued From page 11 POS (Physician order sheet) dated 4/29/17 documented the following order: "Baclofen Tab [1] (tablet) 10 mg (milligrams) FOR: Lioresal tab 10 mg ONE-HALF TAB oral three times daily (8:00 am, 12:00 pm, 4:00 pm) once per day (8:00 am, 12 pm, 4:00 pm) 1/2 tablet by mouth three time a day for muscle spasms (sic) give 5 mg by mouth once a day." This order was initiated on 6/9/14. Review of Resident #6's May 2017 MAR (Medication Administration Record) documented the following: "Baclofen Tab 10 mg for: Lioresal Tab 10 MG one-half tab three times daily; once per day; oral...extended directions: 1/2 tablet by mouth 3 times a day for muscle spasms (sic) give 5 mg by mouth once a day." Further review of the MAR revealed that Resident #6 received Baclofen 5 mg every day, three times a day 5/1/17 through 5/24/17. On 5/25/17 at 9:18 a.m., an interview was conducted with LPN (licensed practical nurse) #6, Resident #12's nurse. When asked what the above order for Baclofen meant, LPN #6 stated, "He should have a 1/2 tablet (5 mg) of the 10 mg three times a day." When LPN #6 was asked to read the next part of the physician order, LPN #6 stated that she wasn't sure why the directions stated, "5 mg by mouth once per day." When asked what Resident #12 should be receiving, LPN #6 stated that Resident #12 should be receiving 5 mg three times a day. LPN #6 stated, "That's what he gets." LPN #6 stated that the order should have been clarified. On 5/25/17 at 9:53 a.m., an interview was conducted with RN (registered nurse) #1, the unit manager. RN #1 was asked when nursing staff	F 281		

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F 281	Continued From page 12 should clarify a physician's order. RN #1 stated that nursing should clarify an order whenever they have a question about the order. RN #1 read the above order for Baclofen and stated, "This doesn't make any sense to me." RN #1 stated that the order should be clarified. When asked what dose Resident #12 should be receiving, RN #1 stated, "I would not know. I would have to look." On 5/25/17 at approximately 12:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Regional QA (quality assurance) manager were made aware of the above findings. ASM #2 stated that the facility uses Lippincott as a professional reference for guiding nursing care. "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. a. Document the scenario ... in the patients chart. .. b. ..Call the attending physician discuss your concerns with him, obtain appropriate .. orders... " Lippincott Manual Of Nursing Practice, Eigth Edition, Lippincott, Williams & Wilkins, page 16. No further information was presented prior to exit. [1] Baclofen- Used to relax certain muscles in the body. It relieves spasms, cramping and tightness of muscles caused by medical conditions such as multiple sclerosis and injuries of the spine. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009200/?report=details	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 281	Continued From page 13 2. The facility staff failed to transcribe a physician order as written for Resident #7. Resident #7 was admitted to the facility on 2/22/17 with diagnoses that included but were not limited to: congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys (1)), urinary tract infection, chronic obstructive pulmonary disease (term used for chronic non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis (2)), atrial fibrillation, high blood pressure and rheumatoid arthritis. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/30/17, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating that she was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. The physician order dated, 3/22/17, documented, "Lorazepam (used to treat anxiety (3)) 1 mg (milligram) tabs (tablets) PO (by mouth) SL (sublingual - under the tongue) every hour PRN (as needed) for anxiety - 1 tab." The March, April, and May 2017 MAR documented, "Lorazepam 1 mg tabs PO SL every hour PRN for pain." The medication was only administered twice in the three months on 3/24/17 at 2:12 p.m. and 3/25/17 at 2:18 a.m.	F 281		

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	495394		05/25/2017

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F 281	Continued From page 14 The comprehensive care plan dated, 4/13/17, documented in part, "Guest is approaching end of life. Hospice services with (Name of Hospice)." The "Approaches/Interventions" documented in part, "Administer medications and treatments as ordered. Observe for ineffectiveness & adverser (sic) reactions, notify physician of abnormal findings." The nurse's note dated, 3/24/17 at 2:12 p.m. documented, "Autocorrected note: Pain level dialog was cancelled by user at 2:12 p.m. when medication was administered." No further documentation on 3/24/17. The nurse's note on 3/25/17 at 2:20 a.m. documented, "Auto created note: Pain level = 5 at 2:18 a.m. when medication was administered; 1. Attempted non-medication intervention for pain; Pain Location/Complaint: moaning sounds; Note: position HOB (head of bed) up." An interview was conducted with LPN (licensed practical nurse) #4, on 2/24/17 at 5:10 p.m. When asked what Lorazepam is used for, LPN #4 stated, "Anxiety." LPN #4 and this surveyor then reviewed the physician order dated, 3/22/17 for Resident #7's Lorazepam and the order documented on the residents March, April and May 2017 MARs. LPN #4 was then asked if Lorazepam was to be administered for pain. LPN #4 stated, "No." LPN #4 stated, "That order should have been clarified." The administrator, ASM #2 and ASM #3, the regional QA (quality assurance) manager, were made aware of the above findings on 5/24/17 at 5:58 p.m. An interview was conducted with administrative	F 281		

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F 281	Continued From page 15 staff member (ASM) #2, the director of nursing, on 5/25/17 at 9:18 a.m. When asked what Lorazepam is used for, ASM #2 stated, "It's for anxiety." When asked if a nurse could administer Lorazepam for pain, ASM #2 stated, "No." The 3/22/17 order for Lorazepam and Resident #7's March, April and May 2017 MARs were shown to ASM #2. ASM #2 stated, "That order (on the MARs) needs to be written as the doctor's order is written. That's a transcription error." A copy of the policy on transcription of orders was requested from ASM #2. According to "Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. On 5/25/17 at 11:35 a.m. ASM #3 informed this surveyor that the facility did not have a policy on transcription of orders." No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 138. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124. (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details	F 281		

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	495394		05/25/2017

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F 282	Continued From page 16	F 282		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the written plan of care for one of 26 residents in the survey sample, Resident #7 and failed to ensure services were provided by qualified personnel for one of 26 residents in the survey sample, Resident #7. a. The facility staff failed to follow the written plan of care for the administration of oxygen to Resident #7. b. The facility staff failed to ensure qualified staff adjusted the oxygen flow rate on a portable oxygen tank for Resident #7. The findings include: a. Resident #7 was admitted to the facility on 2/22/17 with diagnoses that included but were not limited to: congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys (1)), urinary tract infection, chronic obstructive	F 282	F Tag 282: Resident # 7's oxygen is in place and on the correct settings ordered by the physician. No negative outcomes occurred. All residents who have an order for supplemental oxygen have the potential to be affected. The DON/designee will educate all licensed staff to include Certified Nursing Assistants on the license requirements for applying and administering oxygen per physician orders. All residents receiving oxygen will be audited to ensure correct settings are in place per physician orders. Any variances will be corrected and continued education will be provided. Observations of oxygen application and administration will be conducted randomly 3x/week for 4 weeks to ensure physicians' orders are followed	7/8/17

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	495394		05/25/2017

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F 282	Continued From page 17 pulmonary disease (term used for chronic non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis (2)), atrial fibrillation, high blood pressure and rheumatoid arthritis. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/30/17, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating that she was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. In Section O - Special Treatments, Procedures and Programs, Resident #7 was coded as receiving oxygen therapy. The comprehensive care plan dated, 4/13/17, documented in part, "Potential for Breathing difficulty: R/T (related to) Asthma, End Stage COPD, heart failure." The "Approaches/Interventions" documented in part, "Administer medications and treatments per physician orders." The physician order dated, 3/22/17, documented, "O2 (oxygen) 2.5 LPM (liters per minute) via NC (nasal cannula) (a device for delivering oxygen by way of two small tubes that are inserted into the nares (3))." On 5/23/17 at 2:58 p.m., Resident #7 was observed in bed. Her oxygen was on via the nasal cannula. The concentrator flow meter was set with the ball sitting between the two and two	F 282	and requirements for application are followed to include only licensed professionals. Variances will be corrected if observed. Continued compliance will be monitored through the facilities quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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	495394		05/25/2017

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F 282	Continued From page 18 and a half line. On 5/24/17 at 8:05 a.m., the resident was observed in bed. The oxygen was not on the resident. The nasal cannula was found on the floor behind the oxygen concentrator. The oxygen concentrator was running and set between two and two and a half LPM." The ball was set between the two lines. When asked if she was supposed to have oxygen, Resident #7 stated, "Yes, I need it on at all times." Resident #7 was observed on 5/24/17 at 10:44 a.m. sitting in her wheelchair. There was an oxygen tank on the back of her wheelchair. The resident was wearing the same nasal cannula that was on the floor previously. The oxygen tank was set at 3 LPM. On 5/24/17 at 1:05 p.m. Resident #7 was observed sitting in her wheelchair with the nasal cannula on and the oxygen flow meter on the oxygen tank was set at 3 LPM. An interview was conducted with LPN #1 on 5/25/17 at 8:47 a.m. When asked who sets the rate on a resident's oxygen equipment, LPN #1 stated, "The nurses." When asked how the rate is set, LPN #1 stated, "The ball has to sit with the prescribed rate running through the center of the ball." When asked if it would be correct to have the flow meter ball is sitting between the two and two and a half line, LPN #1 stated, "No, the line has to go through the center of the ball." An interview was conducted with RN (registered nurse) #1, the unit manager, on 5/25/17 at 9:05 a.m. When asked how to read an oxygen concentrator, RN #1 stated, "I get down on one knee and look it and adjust the knob to the	F 282		

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F 282	Continued From page 19 correct rate." When asked how the flow meter ball should be positioned for the correct flow rate, RN #1 stated, "The ball should in n the center of the line of the prescribed rate." An interview was conducted RN #1, the unit manager, on 5/25/17 at 10:00 a.m. When asked the purpose of the care plan, RN #1 stated, "It's the guide to providing care to each resident." When asked who checks that the care plan interventions are being followed, RN #1 stated, "We should follow up on room rounds." When asked if the nurse should be checking if interventions are in place per the plan of care, RN #1 stated, "Yes, during the treatments they do with the resident." Facility policy titled, "Interdisciplinary Care Plan," documented the following: It is the policy of this facility to develop an interdisciplinary care plan for each guest that includes measurable goals and time frames directed towards achieving and maintaining each guest's optimal medical, physical, mental and psychosocial needs." This policy did not address following the care plan. According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."	F 282		

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	495394		05/25/2017

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F 282	Continued From page 20 The administrator, director of nursing and regional QA (quality assurance) manager, were made aware of the above findings on 5/25/17 at 12:15 p.m. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 138. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124. (3) This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/nasal+cannula b. The facility staff failed to ensure qualified staff adjusted the oxygen flow rate on a portable oxygen tank for Resident #7. The physician order dated, 3/22/17, documented, "O2 (oxygen) 2.5 LPM (liters per minute) via NC (nasal cannula)." On 5/23/17 at 2:58 p.m., Resident #7 was observed in bed. Her oxygen was on via the nasal cannula. The concentrator flow meter was set with the ball sitting between the two and two and a half line. On 5/24/17 at 8:05 a.m., the resident was observed in bed. The oxygen was not on the resident. The nasal cannula was found on the floor behind the oxygen concentrator. The oxygen concentrator was running and set between two and two and a half LPM." The ball was set between the two lines. When asked if	F 282		

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F 282	Continued From page 21 she was supposed to have oxygen, Resident #7 stated, "Yes, I need it on at all times." Resident #7 was observed on 5/24/17 at 10:44 a.m. sitting in her wheelchair. There was an oxygen tank on the back of her wheelchair. The resident was wearing the same nasal cannula that was on the floor previously. The oxygen tank was set at 3 LPM. On 5/24/17 at 1:05 p.m. Resident #7 was observed sitting in her wheelchair with the nasal cannula on and the oxygen flow meter on the oxygen tank was set at 3 LPM. An interview was conducted with LPN (licensed practical nurse) #4 on 5/24/17 at 5:10 p.m. LPN #4 was asked who sets the flow rate on the oxygen concentrators for residents receiving oxygen. LPN #4 stated, "The nurses." When asked who sets the flow rate on portable oxygen tanks for residents requiring oxygen, LPN #4 stated, "The nurse should." When asked if a CNA (certified nursing assistant) can adjust the oxygen, LPN #4 stated, "I am pretty sure that they can't." An interview was conducted with CNA #2 on 5/24/17 at 5:02 p.m. When asked who adjusts the oxygen flow rate on oxygen concentrators, CNA #2 stated, "The nurse." When asked who adjusts the oxygen flow rate, if a resident is moved from the bed to a wheelchair and is transferred from a concentrator to a portable oxygen tank, CNA #2 stated, "Whoever transfers them, if it's me, I do. Or if it's the nurse or therapy, they adjust the rate; it's whoever does the transfer." An interview was conducted with LPN #1 on 5/25/17 at 8:47 a.m. When asked who sets the	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 282	Continued From page 22 oxygen flow rate on a resident's oxygen equipment, LPN #1 stated, "The nurses." An interview was conducted with CNA #4 on 5/25/17 at 9:02 a.m. CNA #4 was asked who disconnects a resident from an oxygen concentrator, and reconnects them to a portable oxygen tank, when transferring from the bed to a wheelchair. CNA #4 stated, "We (the CNAs) hook it up." When asked if she sets the oxygen flow rate on the portable oxygen tank, CNA #4 stated, "Yes, we match what is on the oxygen concentrator." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 5/25/17 at 9:18 a.m. When asked who sets the flow rate of an oxygen concentrator or oxygen tank, ASM #2, stated, "The nurse." ASM #2 was asked who would turn on and adjust the oxygen flow rate on a portable tank, if a resident was transferred from the bed to a wheelchair, and is moved from an oxygen concentrator to a portable oxygen tank. ASM #2 stated, "Airing on the side of caution, the nurses should move it. Oxygen is considered a medication so really the nurses should adjust the rate." According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 282	Continued From page 23 The administrator, director of nursing and regional QA (quality assurance) manager, were made aware of the above findings on 5/25/17 at 12:15 p.m.	F 282		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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, including but not limited to the following: (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. (l) Dialysis. The facility must ensure that	F 309		7/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 309	Continued From page 24 residents who require dialysis receive 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 documentation review, and clinical record review, it was determined that facility staff failed to provide the necessary care and services to maintain the highest practicable level of physical well-being for three of 26 residents in the survey sample, Resident #4, and #13 and #7. 1. The facility staff failed to apply TED stockings per the physician's order for Resident #4. 2. The facility staff failed to follow the physician's orders to monitor Resident #13's fluid intake and output. Resident #13 was ordered to be on a daily fluid restriction. 3. The facility staff failed to administer Lorazepam per the physician order for Resident #7. The findings include: 1. The facility staff failed to apply TED stockings per the physician's order for Resident #4. Resident #4 was admitted to the facility on 1/16/17 and readmitted on 3/20/17 with diagnoses that included but were not limited to: Parkinson's disease (1), urinary tract infection, and low blood pressures. The most recent MDS (minimum data set), a 14	F 309	F Tag 309: Resident #4's TED stockings are applied per physician order. Resident #13 has I&O monitoring in place per physician order. Resident #7 only receives Lorazepam PRN if indicated for anxiety per physician order. All residents have the potential to be affected related to following physician orders. The ADON/designee will educate all licensed staff on following physician orders with a specific focus on accurately documenting nursing interventions and outcomes. The Unit managers will audit physician orders specifically TED hose, I&O's and psychoactive medications along with documentation daily at least 3 times per week during clinical operations meeting for current residents and new admissions. Any variances identified will be corrected and continued education provided. Continued compliance will be monitored through the facilities quality assurance program. Additional education and monitoring will be initiated for any	

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	495394		05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 25 day assessment, with an ARD (assessment reference date) of 4/3/17 coded the resident as having scored a five out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could do after staff set up the meal tray. Review of the physician's order dated 5/3/17 documented, "TED STOCKINGS (2) BELOW THE KNEE, BI-LATERAL (sic); APPLY IN AM; REMOVE HS (bedtime)..." Review of the May 2017 TAR (treatment assessment record) documented, "TED STOCKINGS BELOW THE KNEE, BI-LATERAL (sic); APPLY IN AM; REMOVE HS...." Further review of the May 2017 MAR documented that the TED stockings had been applied and removed on 15 occasions. The TED stockings had been documented as being applied but not removed on five occasions. There was no documentation that the TED stockings had been applied and removed on 5/24/17. Review of the May 2017 nurses' notes did not evidence documentation regarding the TED stockings. Review of the care plan initiated on 3/31/17 did not evidence documentation regarding the TED stockings. An observation was made of Resident #4 on 5/24/17 at 1:40 p.m. The resident was sitting up in a wheelchair. RN (registered nurse) #1, the unit manager raised Resident # 4's pant legs. The	F 309	identified concerns.	

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	495394		05/25/2017

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F 309	Continued From page 26 resident was not wearing TED stockings. An observation was made of Resident #4 on 5/24/17 at 3:15 p.m. The resident was sitting in the wheelchair in the hall. The resident was not wearing TED stockings. An interview was conducted on 5/24/17 at 3:02 p.m. with CNA #1 (certified nursing assistant), the resident's aide. When asked how staff knew what care residents needed, CNA #1 stated, "I assess my residents every morning when I do my rounds." When asked if there was any document for staff use that listed the needs of the resident, CNA #1 stated, "I don't know." LPN (licensed practical nurse) #6 was sitting at the nurse's station and stated, "You can check the care card." When CNA #1 was asked if she had put TED stockings on Resident #4 that day, CNA #1 stated, "I didn't get him ready this morning. He was already dressed when I got here." When asked if the resident was to wear TED stockings, CNA #1 stated she did not know. When asked if she had ever seen the resident wearing TED stockings, CNA #1 stated, "No." An interview was conducted on 5/14/17 at 3:15 p.m. with RN #1. When asked how staff knew what care residents needed, RN #1 stated, "They get report from their CNA going off and report from their nurses and there should be a care card in their (the resident's) wardrobe." When asked who applied TED stockings, RN #1 stated, "The aides can." When asked how the nurse knew to chart that the TED stockings were on the resident, RN #1 stated, "They ask or they look. They can easily see them when they're in the room giving meds (medications). I'll get someone to put them on (Resident #4) right away." A	F 309		

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	495394		05/25/2017

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F 309	Continued From page 27 request was made for Resident #4's care card at that time. An interview was conducted on 5/24/17 at 3:20 p.m. with LPN #1, Resident #4's nurse. When asked if nurses gave report to the aides, LPN #1 stated, "We tell them if there is anything new or unusual (with the resident)" When asked if she would tell the aide that the resident was to wear TED stockings, LPN #1 stated, "No." When asked how nurses knew if a resident had their TED stockings on, LPN #1 stated, "I have to look and see." When asked if she had looked to see if Resident #4 had TED stockings on that day, LPN #1 stated, "I don't remember." When asked if there was any reason not to apply the TED stockings, LPN #1 stated there was not. An interview was conducted on 5/24 at 3:30 p.m. with CNA #6, the CNA who was to apply the TED stockings on Resident #4. CNA #6 was standing at the nurse's station with an unopened package of TED stockings. When asked if Resident #4 had TED stockings in his room, CNA #6 stated there were no stockings in the resident's room. When asked if she had ever seen Resident #4 with TED stockings on, CNA #6 stated, "Honestly I haven't but I'm not his usual aide, I only sit with him sometimes." On 5/24/17 at 3:35 p.m. RN #1 reviewed the care card with this surveyor. RN #1 stated, "The care card doesn't state that (the resident was to have TEDs) so the aide wouldn't know that." On 5/24/17 at 5:40 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nurses and ASM #3, the regional QA (quality assurance) manager were made aware of	F 309		

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	495394		05/25/2017

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F 309	Continued From page 28 the findings. A request for a policy on following doctor's orders was requested at that time. On 5/25/17 at 9:05 a.m. ASM #3 stated, "We don't have a policy on following MD (medical doctor) orders." No further information was provided prior to exit. (1) Parkinson's disease -- Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html (2) TED stockings -- TED stockings (compression stockings) to help prevent blood clots, a possible complication of surgery. This information was obtained from: https://www.cc.nih.gov/ccc/patient_education/postop/prepinpatientsurg.pdf 2. The facility staff failed to follow the physician's orders to monitor Resident #13's fluid intake and output. Resident #13 was ordered to be on a daily fluid restriction. Resident #13 was originally admitted to the facility on 12/26/16 and most recently readmitted on 5/15/17 with diagnoses including, but not limited to: congestive heart failure, chronic kidney disease, dementia, heart disease, and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 4/18/17, she was coded as	F 309		

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F 309	Continued From page 29 being cognitively intact for making daily decisions. Resident #13 was coded as frequently incontinent of bladder. She was coded as having received medication to eliminate excess fluid for four days during the look back period. A review of Resident #13's clinical record revealed the following physician's order dated 5/15/17 and signed by the physician on 5/16/17: "Intake and Output every shift (day, eve [evening], night) 1500 ml (milliliter) fluid restriction (500 ml per shift)." A review of the MARs (medication administration records) and TARs (treatment administration records) revealed no evidence of the amount of fluids taken in by Resident #13, totaled by shift, from 5/15/17 through 5/24/17. The TARs contained nurse initials in the boxes for the fluid restriction, but no numerical totals. The resident had not been in the facility long enough for a comprehensive care plan to have been developed. On 5/24/17 at 8:50 a.m., ASM (administrative staff member) #4, the attending physician and medical director, was interviewed. He stated that an order for intake and output "generically is looking at a resident's hydration status." He stated: "I'd have to check with the nurse practitioner. I'd have to defer to the nurse practitioner or look at the chart to determine exactly why this order was put in place." He stated he was currently out of town and the nurse practitioner was unavailable for interview. On 5/24/17 at 9:30 a.m., LPN (licensed practical nurse) #9 was interviewed. She stated Resident	F 309		

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	495394		05/25/2017

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F 309	Continued From page 30 #13 is incontinent of bladder and that the resident's family often comes in and provides the resident with additional fluids. When asked if the facility staff is recording the amount of fluid the resident takes in, LPN #9 stated: "Sometimes we write it down. But I can't think of a time when I did." She stated the staff are not adding up and totaling the fluid intake for each shift. LPN #9 stated: "We are not keeping a running total every day." She stated the initials in the boxes on the TAR mean that the resident has not had more than 500 mls (milliliter) in a shift. She stated there were no totals recorded since the order was put in place. On 5/24/17 at 3:10 p.m., CNA (certified nursing assistant) #1 was interviewed. When asked if she was aware of any limitations on Resident #3's fluid intake, she stated that she was not aware of any. CNA #1 stated: "I have never worked with [Resident #13] before, and I am new. Today is my first day with her. I am a new CNA so I am just trying to learn." On 5/24/17 at 5:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional QA (quality assurance) manager, were informed of these concerns. ASM #2 stated that the fluid amounts taken in by the resident should be recorded each shift. A review of the facility policy "Fluid Restriction" revealed, in part, the following: "All guests with a nutrition prescription for a fluid restriction shall receive only the amount of fluids as prescribed by the physician...The distribution of fluids shall be documented on the dietary progress notes, care plan, and the Medication Administration Record or Treatment Administration Record. For guests	F 309		

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	495394		05/25/2017

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F 309	Continued From page 31 placed on a fluid restriction, an Intake/Output record shall be maintained by nursing. The intake/output record shall be completed for at least 7 days. It is recommended that this be completed for at least 30 days after the guest's intake/output have become stable." No further information was provided prior to exit. 3. The facility staff failed to administer Lorazepam per the physician order for Resident #7. Resident #7 was admitted to the facility on 2/22/17 with diagnoses that included but were not limited to: congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys (1)), urinary tract infection, chronic obstructive pulmonary disease (term used for chronic non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis (2)), atrial fibrillation, high blood pressure and rheumatoid arthritis. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/30/17, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating that she was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. The physician order dated, 3/22/17, documented,	F 309		

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	495394		05/25/2017

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F 309	Continued From page 32 "Lorazepam (used to treat anxiety (3)) 1 mg (milligram) tabs (tablets) PO (by mouth) SL (sublingual - under the tongue) every hour PRN (as needed) for anxiety - 1 tab." The March, April, and May 2017 MAR documented, "Lorazepam 1 mg tabs PO SL every hour PRN for pain." The medication was only administered twice in the three months on 3/24/17 at 2:12 p.m. and 3/25/17 at 2:18 a.m. The comprehensive care plan dated, 4/13/17, documented in part, "Guest is approaching end of life. Hospice services with (Name of Hospice)." The "Approaches/Interventions" documented in part, "Administer medications and treatments as ordered. Observe for ineffectiveness & adverser (sic) reactions, notify physician of abnormal findings." The nurse's note dated, 3/24/17 at 2:12 p.m. documented, "Autocorrected note: Pain level dialog was cancelled by user at 2:12 p.m. when medication was administered." No further documentation on 3/24/17. The nurse's note on 3/25/17 at 2:20 a.m. documented, "Auto created note: Pain level = 5 at 2:18 a.m. when medication was administered; 1. Attempted non-medication intervention for pain; Pain Location/Complaint: moaning sounds; Note: position HOB (head of bed) up." An interview was conducted with LPN (licensed practical nurse) #4, on 2/24/17 at 5:10 p.m. When asked what Lorazepam is used for, LPN #4 stated, "Anxiety." LPN #4 and this surveyor then reviewed the physician order dated, 3/22/17 for Resident #7's Lorazepam and the order documented on the residents March, April and	F 309		

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	495394		05/25/2017

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F 309	Continued From page 33 May 2017 MARs. LPN #4 was then asked if Lorazepam was to be administered for pain. LPN #4 stated, "No." LPN #4 stated, "That order should have been clarified." The administrator, ASM #2 and ASM #3, the regional QA (quality assurance) manager, were made aware of the above findings on 5/24/17 at 5:58 p.m. An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 5/25/17 at 9:18 a.m. When asked what Lorazepam is used for, ASM #2 stated, "It's for anxiety." When asked if a nurse could administer Lorazepam for pain, ASM #2 stated, "No." The 3/22/17 order for Lorazepam and Resident #7's March, April and May 2017 MARs were shown to ASM #2. ASM #2 stated, "That order (on the MARs) needs to be written as the doctor's order is written. That's a transcription error." A copy of the policy on transcription of orders was requested from ASM #2. According to "Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. On 5/25/17 at 11:35 a.m. ASM #3 informed this surveyor that the facility did not have a policy on transcription of orders." No further information was provided prior to exit.	F 309		
F 314	TREATMENT/SVCS TO PREVENT/HEAL	F 314		7/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314 SS=G	Continued From page 34 PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 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 identify, monitor and implement care and services for the prevention, identification, and treatment of pressure injuries for two of 26 residents in the survey sample, Resident #7 and Resident #3. 1. a. Facility staff failed to identify a pressure injury on Resident #7's left great toe until it was at an advanced stage; the pressure sore was found on 5/2/17, and staged as a Stage III wound, measuring 3 x 3, centimeters in size with a necrotic area in the center, resulting in harm. Facility staff also failed to assess, monitor and measure the wound for three weeks.	F 314	F Tag 314: Resident #7's and #3's pressure ulcers are assessed and measured weekly. All residents with pressure ulcers have the potential to be affected by this practice. A 100% skin audit of all current residents has been completed to ensure all identified pressure areas are assessed, measured and treated. Physician contact will be made with resulting changes to the plan of care if indicated. The ADON/designee will educate all	

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	495394		05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 35 1.b. Facility staff failed to monitor, and measure a pressure injury on Resident #7's heel that was found at a Stage II blister on 5/9/17. There were no measurements or monitoring of this wound and it was observed on 5/24/17 with a black area. In addition the facility staff failed to apply heel lift boots as ordered by the physician. 2. The facility staff failed to measure Resident #3's toe pressure ulcer on 4/14/17 and 4/21/17. The findings include: 1. a. Facility staff failed to identify a pressure injury on Resident #7's left great toe until it was at an advanced stage; the pressure sore was found on 5/2/17, and staged as a Stage III wound, measuring 3 x 3, centimeters in size with a necrotic area in the center, resulting in harm. Facility staff also failed to assess, monitor and measure the wound for three weeks. *A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (1) **Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present.	F 314	licensed nursing staff on skin-care protocols, including the initial skin assessment, weekly skin assessments, shower documentation, observations during personal care, wound descriptions, and staff/physician communication. Certified Nursing Assistants will be educated on ensuring pressure relieving devices are in place per orders. The care card system will be utilized as a communication tool for all pressure relieving devices. Additionally all certified nurse assistants will be educated on turning and positioning every 2 hours for all residents that are unable to position themselves. Licensed Nurses will conduct a full skin assessment weekly on all residents, along with any new admissions and contact a physician when required. The Administrative Nurses will conduct wound rounds weekly to verify current orders and measurements are accurate. Any variances will be corrected. Additional training will be provided when needed. Administrative Nurses will audit weekly skin assessments during the daily clinical meeting 5x/week for 4 weeks to ensure that physician communication and interventions have been implemented for any areas identified, and that areas have been properly described. In addition, the	

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	495394		05/25/2017

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F 314	Continued From page 36 Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (2) Resident #7 was admitted to the facility on 2/22/17 with diagnoses that included but were not limited to: congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys (3)), urinary tract infection, chronic obstructive pulmonary disease (term used for chronic non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis (4)), atrial fibrillation, high blood pressure and rheumatoid arthritis (a chronic destructive disease characterized by joint inflammation (5)). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/30/17, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating that she was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. In Section M - Skin Conditions, the resident was coded as being at risk for pressure ulcers (injuries) but had no pressure injuries at the time of the assessment.	F 314	Administrative Nurses will continue to review the weekly skin sheets and shower sheets daily in the clinical operations meeting for accuracy and completeness, and report any new areas to the physician for 3 months. The results of the daily audits will be reviewed in the monthly Quality Assurance meeting with additional monitoring and education provided as indicated.	

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	495394		05/25/2017

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F 314	Continued From page 37 Resident #7 was observed on 5/23/17 at 2:58 p.m., in her bed. She had white cotton socks on her feet and her feet were on a pillow, but her heels were touching the mattress. Resident #7 had no protective boots on her feet. The resident was on top of the covers with a light fleece blanket over her legs; her feet were not under the blanket. Resident #7 was observed on 5/23/17 at 4:50 p.m., in her bed reading a book. Her feet were on a pillow, but her heels were touching the surface of the mattress. She had no shoes or boots on her feet just cotton white socks. Resident #7 stated to this surveyor, "I have a sore on my big toe." The resident was on top of the covers with a light fleece blanket over her legs. The resident removed her blanket to show this surveyor her feet with her white socks on. Resident #7 was observed on 5/24/17 at 8:05 a.m. She was resting in bed, with the covers over her. She had no boots on her feet. A physician order dated, 5/2/17 documented, "Cleanse L (left) great toe, apply Santyl* oint (ointment) and DD (dry dressing) Q (every) day." *Santyl is a sterile enzymatic debriding ointment used to that has a unique ability to digest collagen in necrotic tissue. (6) The nurse practitioner's note dated, 5/2/17, documented in part, "Chief Complaint: L (left) great toe. Interval History: Staff report ulcer L (left) great toe, denies pain, isn't sure when it occurred. Key Findings: L great toe deformed, stage 3 ulcer 3 x 3, redness surrounding area 5 x 6, necrotic area in center."	F 314		

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F 314	Continued From page 38 The nurse's notes documented, "5/5/17 at 3:21 p.m. LATE ENTRY FOR 5/2/17. Late Entry for 5/2/17. This guest noted with area to left great toe. NP (nurse practitioner) notified 5/2/17 at 10:30 a.m. New Treatment initiated." Further review of the clinical record did not reveal any further documentation of the left great toe pressure ulcer. On 5/24/17 at approximately 9:30 a.m. a request was made to the director of nursing, for any skin assessments, wound care measurements or anything related to the pressure wound on Resident #7's left great toe. On 5/24/17 at 1:50 p.m. administrative staff member (ASM) #2, the director of nursing presented three documents for Resident #7. The first two pages were "Weekly Skin Assessment" dated 2/22/17 through 5/21/17. The first date anything related to the feet was documented was on 5/21/17. The 5/21/17 skin assessment documented, "Has new pressure Ulcer - indicate with X and see Pressure Ulcer Record." On the body diagram, an arrow pointed to the left foot and a circle was surrounding the buttocks area. There was no documentation regarding Resident #7's left great toe. The next document presented by ASM #2 on 5/24/17 at 1:50 p.m. documented, "Pressure Ulcer Record." This form documented the following: Date: 5/2/17: Site: L great toe; Stage: III; Length/width/depth: 1.8 x 1.6 x 0.1 (measured in centimeters); Odor: none; Drainage: S (serosanguinous); Color: B (black - eschar) R	F 314		

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	495394		05/25/2017

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F 314	Continued From page 39 (red). Date 5/24/17: Site: L great toe; Stage: III; Length/width/depth: .3 x .2; Odor: none; Drainage: O (none); Color: redness. There were no measurements from 5/2/17 until 5/24/17, which was done by the unit manager on 5/24/17. On 5/24/17 at 2:18 p.m., a request to speak to the nurse practitioner that first examined the L great toe wound was made to ASM #2, the director of nursing. ASM #2 informed this surveyor that the nurse practitioner was out on emergency medical leave. ASM #2 further stated that the facility had not have a wound care nurse for several weeks. The new wound care nurse started two weeks ago in orientation and her first day on the floor was 5/22/17. The left great toe wound was observed on 5/24/17 at 2:50 p.m. with RN (registered nurse) #3, the wound care nurse. Resident #7's left foot was deformed from her rheumatoid arthritis. The left great toe, with the pressure ulcer, was bent at a 90 degree angle, at the first joint behind the toenail, and was turned toward the other toes. With this deformity, the nail and top of the first joint of the great toe, was observed as the highest point of Resident #7's foot. (If you make a fist with your hand and bend your thumb so the tip of your thumb touches behind your second knuckle, that is how Resident #7's toe and toes are positioned). RN #3 proceeded to clean the wound with normal saline, and Resident #7 stated, "That hurts." RN #3 offered to stop the wound care at this time and get some pain medication, but Resident #7 declined and stated, "Just do it PDQ (pretty damn quick)." The area was described by RN #3, (who stated she has done wound care for five years),	F 314		

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	495394		05/25/2017

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F 314	Continued From page 40 as follows: erythema noted around the border, yellow slough noted, no drainage, rash or odor noted, measuring 1 cm (centimeter) L (length) x 1 cm W (width). Tenderness noted with palpitation. The area of erythema was not blanchable. On 5/24/17 at 3:50 p.m. this surveyor spoke with ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the QA (quality assurance) manager and RN #3, the wound care nurse. This surveyor expressed concern for this resident's wounds. When asked why there were no measurements from 5/2/17 through 5/24/17, there was a long silence, no one spoke. ASM #1 then stated, "We didn't have a wound care nurse at the time." This surveyor asked for the facility staff to provide any information related to this wound. The comprehensive care plan dated, 4/13/17, with a revised on date of 5/2/17, documented, "Potential for impaired skin integrity related to decreased mobility, preventative measures to bil (bilateral) heels, Max (maximum) assist - dependent on staff for ADL (activities of daily living), incontinent of B & B (bowel and bladder), Hx (history) of COPD, CHF (congestive heart failure). 5/2/17 - area to (L) great toe." The "Approaches/Interventions" documented in part, "Float heels while in bed as guest tolerates. Pressure reduction mattress on bed. Conduct weekly head to toe skin assessments, document and report abnormal findings to physician. Evaluation skin with each episode and report any redness, skin breakdown, rash, pain, burning, odorous urine, to nurse. 5/2/17 - treatment in progress." Review of Resident #7's May 2017 TAR	F 314		

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	495394		05/25/2017

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F 314	Continued From page 41 (treatment administration record) documented, "Santyl Ointment: daily for wound healing. Extended directions: Cleanse area left great toe with n/s (normal saline) apply Santyl oint (ointment) and dd (dry dressing) q (every) day." The treatment was signed as completed every day except on 5/10/17 and 5/22/17. An interview was conducted with CNA (certified nursing assistant) #5, on 5/24/17 at 3:05 p.m. When asked how often a CNA looks at a resident's skin, CNA #5 stated, "Every time I take their clothes off or wash them up." An interview was conducted with LPN (licensed practical nurse) #1, the nurse that documented the L great toe wound initially, on 5/25/17 at 8:47 a.m. LPN #1 was asked to describe the area on Resident #7's left great toe when she found it. LPN #1 stated, "It was dark, brown in color. It wasn't opened; it looked like eschar, dark." When asked if there was redness around the area, LPN #1 stated, "I don't remember, I remember it was dark like a red light. The resident wasn't eating much and was near death but she had rallied lately." On 5/25/17 at 9:18 a.m. an interview was conducted with ASM #2. ASM #2 was asked about the blanks on the TAR for the treatment of Resident #7's left great toe. ASM #2 stated, "The nurses tell me the computer goes down. I believe this is all due to the fluctuation in having a treatment nurse. The former treatment nurse left and now we have a new treatment nurse. Folks didn't have the 'moxie' to do it (the treatments). We don't know if those treatments were done or not done. The old nursing adage - if it ain't documented it wasn't done."	F 314		

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F 314	Continued From page 42 On 5/25/17 at 9:37 a.m. ASM #1, ASM #2, and ASM #3 were informed of the concern for harm for Resident #7. ASM #3 stated, "We have given you everything we have." This surveyor asked to speak with ASM #4, the attending physician, who was out of town, regarding any knowledge he had of Resident #7's wounds. An interview was conducted with RN #1, the unit manager; on 5/25/17 at 10:00 a.m. RN #1 was asked about the process for assessing resident's skin. RN #1 stated, "On admission we check them head to toe for the first three shifts. Then skin assessments are done weekly. If an issue is found we notify the wound care nurse." RN #1 was asked what is expected of staff, if a CNA finds something new or different than before on a resident's skin. RN #1 stated, "The CNA informs the nurse. We also have a shower team and they do a 'stop and watch' form to let us know. If they find anything shocking, they come get me." When asked how treatment is implemented for a newly found area, RN #1 stated, "We call the doctor and get orders." When asked who completes the weekly wound measurements, RN #1 stated, "The wound care nurse measures every week. We had (name of former wound care nurse) and now we have (name of RN #3). When asked who completed the weekly wound measurements while there wasn't a wound care nurse, RN #1 stated, "I thought the previous DON (director of nursing) had assigned a treatment nurse to do the treatments and measurements." 5/25/17 at 11:14 a.m. ASM #3 stated she had left a message for ASM #4. On 5/25/17 at 11:35 a.m. ASM #3 informed this surveyor that there was no return call from ASM #4. At 12:07 p.m. on	F 314		

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F 314	Continued From page 43 5/25/17, ASM #3 informed this surveyor that ASM #4 had called and he had not seen Resident #7's wounds to comment on them. The facility policy, "Pressure Ulcer Identification and Treatment Protocol" documented in part, "Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Stage III pressure ulcer varies by anatomical locations. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage III ulcers can be shallow. Interventions: 3. Evaluation the need for pressure reduction relief surface for bed and pressure reduction cushion for chair. Consider low air loss therapy. 5. Turn and reposition every 2 hours or more often if indicated. Use pillow for positioning, avoid skin to skin contact/use pillows or foam wedge to position individual without placing pressure on boney prominences and between boney prominences. If the individual has large Stage III ulcers, a low -air- loss or air-fluidized support surface may be indicated...Evaluate the wound at each dressing change. Document site, stage, length, width, depth (cm), color, treatment and progress at least weekly and if condition of the wound changes. The Pressure Ulcer Treatment Quick Reference Guide by NPUAP states on page 8 concerning pressure ulcer assessment, "Asses the pressure ulcer initially and re-assess it at least weekly, documenting findings...A 2-week period is recommended for evaluating progress toward healing. However, weekly assessments provide an opportunity for the health care professional to	F 314		

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F 314	Continued From page 44 detect early complications and the need for changes in the treatment plan." Page 9 of this reference states, "With each dressing change, observe the pressure ulcer for developments that may indicate the need for a change in treatment (e.g., wound improvement, wound deterioration, more or less exudate, signs of infection, or other complications)...Assess and accurately document physical characteristics such as location, Category/Stage, size, tissue type (s), wound bed and periwound condition, wound edges, sinus tracts, undermining, tunneling, exudate, necrotic tissue, odor, presence/absence of granulation tissue, and epithelialization." Page 10 of this reference states, "Re-evaluate the pressure ulcer, the plan of care, and the individual if the pressure ulcer does not show progress toward healing within 2 weeks (or as expected given the individual's overall condition and ability to heal)...Signs of deterioration should be addressed immediately." This information was obtained from: National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel. Pressure Ulcer Prevention and Treatment: Clinical Practice Guideline. Washington, DC: National Pressure Ulcer Advisory Panel, Second edition published 2014. No further information was provided prior to exit. (1) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages. (2) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages. (3) Barron's Dictionary of Medical Terms for the	F 314		

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F 314	Continued From page 45 Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 138. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124. (5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 511. (6) This information was obtained from the following website: http://www.rxlist.com/santyl-drug.htm. 1.b. Facility staff failed to monitor, and measure a pressure injury on Resident #7's heel that was found at a Stage II blister on 5/9/17. There were no measurements or monitoring of this wound and it was observed on 5/24/17 with a black area. In addition the facility staff failed to apply heel lift boots as ordered by the physician. The nurse practitioner's note dated, 5/9/17, documented, "Chief Complaint: Left heel. Interval History: Staff reports areas of left heel, complains of increased pain to right heel, states appetite diminished and not eating entire meals, is drinking supplement, discussed with hospice nurse hospice to provide air mattress. Key Findings: Left heel intact bullae (blister; a large bleb in the skin that contains fluid (1)). Assessment and Plan: 2. Bullae - acute- heel lift boots, skin breakdown most likely due to poor nutritional status, will not check labs (laboratory tests) due to hospice status will most likely find protein-calorie malnutrition if drawn." The physician order dated, 5/9/17, documented, " Skin prep* L (left) heel q (every) shift and PRN (as needed). Heel lift boots QD (every day)."	F 314		

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F 314	Continued From page 46 *Skin Prep is a liquid film-forming dressing that forms a protective film to help reduce friction during removal of tapes and films. The Skin Prep also protects fragile skin. (2) Resident #7 was observed on 5/23/17 at 2:58 p.m., in her bed. She had white cotton socks on her feet and her feet were on a pillow but her heels were touching the mattress. She had no protective boots on her feet. Resident #7 was on top of the covers with a light fleece blanket over her legs; her feet were not under the blanket. Resident #7 was observed on 5/23/17 at 4:50 p.m., in her bed reading a book. Her feet were on a pillow but her heels were touching the mattress. She had no shoes or boots on her feet just cotton white socks. Resident #7 stated to this surveyor, "I have a sore on my big toe." The resident was on top of the covers with a light fleece blanket over her legs. Resident #7 removed her blanket to show this surveyor her feet with her white socks on. Resident #7 was observed on 5/24/17 at 8:05 a.m. She was resting in bed. The covers were over her. She had no boots on her feet. She had a pillow under her calves but her heels were resting on the surface of the bed. Review of the nurse's notes did not reveal any documentation regarding the area on Resident #7's left heel. On 5/24/17 at approximately 9:30 a.m. a request was made for any skin assessments, wound care measurements or anything related to the area on the resident's left heel to the director of nursing, ASM #2.	F 314		

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F 314	Continued From page 47 On 5/24/17 at 1:50 p.m. administrative staff member (ASM) #2, the director of nursing presented three documents for Resident #7. The first two pages were "Weekly Skin Assessment" from 2/22/17 through 5/21/17. The first time anything related to the feet was documented was on 5/21/17. The 5/21/17 skin assessment documented, "Has new pressure Ulcer - indicate with X and see Pressure Ulcer Record." On the body diagram, an arrow pointed to the left foot and a circle was surrounding the buttocks area. There was no documentation regarding the left heel pressure sore. This was verified with ASM #2, the director of nursing. ASM #2 also verified the facility had no measurements of the left heel pressure sore. On 5/24/17 at 2:18 p.m., a request to speak to the nurse practitioner that first examined the L great toe wound was made to ASM #2, the director of nursing. ASM #2 informed this surveyor that the nurse practitioner was out on emergency medical leave. ASM #2 further stated that the facility had not have a wound care nurse for several weeks. The new wound care nurse started two weeks ago in orientation and her first day on the floor was 5/22/17. Resident #7's left heel was observed on 5/24/17 at 2:50 p.m. with RN (registered nurse) #3, the wound care nurse. The left heel was noted to have a dry area that RN #3 measured as 3 cm x 2.2 cm. A black area, under the skin, was observed and was measured as 1 cm x 1 cm by RN #3. RN #3 stated Resident #7's left heel was soft but not boggy. At this time, Resident #7's heel lift boots were observed in her closet.	F 314		

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F 314	Continued From page 48 On 5/24/17 at 3:50 p.m. this surveyor spoke with ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the QA (quality assurance) manager and RN #3, the wound care nurse. Concern was expressed regarding Resident #7's wounds. When asked why there were no measurements for the area on Resident #7's left heel, there was a long silence and no one responded. ASM #1, then stated, "We didn't have a wound care nurse at the time." At this time a request was made for the facility staff to provide any information related to the left heel wound. The wound care nurse documented on 5/24/17 at 4:59 p.m. "Assessment of left heel. Soft, dry callused circular area noted 3.0 cm L (length) x 2.2 cm W (width). Black area noted, 1.0 cm L x 1.0 cm W." An interview was conducted with LPN #4 on 5/24/17 at 5:10 p.m. When asked how often a nurse looks at a resident's skin, LPN #4 stated, "Weekly." When asked how skin assessments are performed by staff, LPN #4 stated, "You provide privacy and then check the resident from head to toe." When asked if staff remove the resident's socks, LPN #4 stated, "Absolutely." When asked how staff ensures physician ordered interventions such as heel lift boots are implemented, LPN #4 stated, "Every time I go in the room I should be checking to ensure everything that is needed is in place." On 5/24/17 at 5:20 p.m. CNA #3 approached this surveyor and asked which boots Resident #7 was supposed to have on her feet. The CNA was referred to the resident's nurse. The comprehensive care plan dated, 4/13/17 and	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 314	Continued From page 49 revised on 5/2/17, documented, "Potential for impaired skin integrity related to decreased mobility, preventative measures to bil (bilateral) heels, Max (maximum) assist - dependent on staff for ADL (activities of daily living) are, incontinent of B & B (bowel and bladder), Hx (history) of COPD, CHF (congestive heart failure). The "Approaches/Interventions" documented in part, "Float heels while in bed as guest tolerates. Pressure reduction mattress. Conduct weekly head to toe skin assessments, document and report abnormal findings to physician. Evaluation skin with each episode and report any redness, skin breakdown, rash, pain, burning, odorous urine to nurse. 5/9/17 - Tx (treatment) to (L) heel as ordered. 5/9/17 - Heel lift boots as ordered." Review of Resident #7's TAR (treatment administration record) for May 2017 revealed, "Treatment every shift and as needed for, Extended directions: Skin prep to left heel." The TAR documented the skin prep was signed off as administered 38 out of the 45 opportunities between 5/9/17 and 5/23/17. A copy of the delivery order for the low air loss mattress dated, 5/9/17, was presented to this surveyor on 5/25/17 at 9:30 a.m. from ASM #2. On 5/25/17 at 8:47 a.m., an interview was conducted with LPN #1, the nurse assigned to Resident #7 on 5/23/17, 5/24/17 and 5/25/17. When asked if she had observed Resident #7's heels on 5/24/17, LPN #1 stated, "No." LPN #1 was asked if she recalled when she had last looked at Resident #7's heels. LPN #1 stated, "She was up in the wheelchair yesterday to go to the beauty shop." When asked if she looked at the resident's heels on Tuesday, LPN #1 stated,	F 314		

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	495394		05/25/2017

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F 314	Continued From page 50 "I don't recall." When asked to describe how she applies the skin prep to Resident #7's heel, LPN #1 stated, "I lift the heel up, apply the skin prep, fan it dry with my hand and then prop the foot on the pillow." When asked if she looks where she is putting the skin prep, LPN #1 demonstrated lifting the foot up and blindly applying the skin prep, fanning it dry with her hand and then replacing it back on the bed. On 5/25/17 at 9:18 a.m. an interview was conducted with ASM #2. When asked about the blanks on the TAR for the treatment of Resident #7's left heel, ASM #2 stated, "The nurses tell me the computer goes down. I believe this is all due to the fluctuation in having a treatment nurse. The former treatment nurse left and now we have a new treatment nurse. Folks didn't have the 'moxie' to do it (the treatments). We don't know if those treatments were done or not done. The old nursing adage - if it ain't documented it wasn't done." An interview was conducted with RN #1, the unit manager, on 5/25/17 at 10:00 a.m. When asked who is responsible for checking to ensure all interventions for pressure ulcers are in place, RN #1 stated, "We should check implementations of the care plan on our room rounds each day." When asked if the nurse should be checking for the interventions, RN #1 stated, "Yes, they should make sure they are in place when they do their treatments." On 5/25/17 at 9:37 a.m. ASM #1, ASM #2, and ASM #3 were informed of the concern for harm for Resident #7. ASM #3 stated, "We have given you everything we have." A request was made to speak with ASM #4, the attending physician, who	F 314		

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	495394		05/25/2017

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F 314	Continued From page 51 was out of town, regarding any knowledge he had of Resident #7's wounds. 5/25/17 at 11:14 a.m. ASM #3 stated she had left a message for ASM #4. On 5/25/17 at 11:35 a.m. ASM #3 informed this surveyor that there was no return call from ASM #4. At 12:07 p.m. on 5/25/17, ASM #3 informed this surveyor that ASM #4 had called and he had not seen Resident #7's wounds to comment on them. The facility policy, Pressure Ulcer Identification and Treatment Protocols" documented in part, "Stage II: Partial thickness skin loss of dermis presenting as a shallow, open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. This area may present as a shiny or dry, shallow ulcer without slough or bruising....Interventions: Position with pillows. Use pillows or foam wedge to position individual without placing pressure on a bony prominence and between bony prominences, (ankles or knees) - remove pressure on heels generally by elevating off the bed (floating the heels).. Document site, stage, length, width, depth (cm), color, treatment and progress at least weekly and if condition of the wound changes." (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 94. (2) This information was obtained from the following website: www.allegromedical.com 2. Facility staff failed to measure Resident #3's toe pressure ulcer on 4/14/17 and 4/21/17.	F 314		

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	495394		05/25/2017

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F 314	Continued From page 52 Resident #3 was admitted to the facility on 9/1/16 with diagnoses that included but were not limited to: seizures, dementia, depression, arthritis and an enlarged heart. The most recent MDS (minimum data set), a quarterly assessment, with an ARD of 2/27/17 coded the resident as having a seven out of 15 on the BIMS indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as not having any open pressure ulcers. Review of the care plan initiated on 10/26/16 and revised on 3/2/17 documented, "Problems/Conclusions. Potential for impaired skin integrity...3/2/17 area to (R) great toe. Approaches/Interventions. Conduct weekly head to toe skin assessments, document and report abnormal findings to physician. 3/2/17 - Tx (treatment) in progress." Review of the physician's orders dated and signed on 5/18/17 documented, "TREATMENT apply skin prep to right gt (great) toe qs (every shift) for dti (deep tissue injury) (1). Start 03-23-17." . Review of the May 2017 TAR (treatment administration record) did not evidence documentation regarding the skin prep treatment to the right great toe. Review of the pressure ulcer record for Resident #3 documented, "INITIAL WOUND DESCRIPTION: Date. 3-2-17. Site R (with a circle around it, indicating right) great toe. Description 0.3x (by) 0.3x0 cm (centimeters) purple." Further	F 314		

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	495394		05/25/2017

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F 314	Continued From page 53 review of the pressure ulcer record for 4/14/17, 4/21/17 and 4/28/17 did not evidence documentation of the measurements or color of the right great toe pressure ulcer. Review of the nurse's notes for 4/14/17, 4/21/17 and 4/28/17 did not evidence documentation regarding the condition of the right great toe pressure ulcer. On 5/24/17 at 5:40 p.m. a request for Resident #3's pressure ulcer form was requested from ASM (administrative staff member) #3, the regional QA (quality assurance) manager. On 5/25/17 at 8:00 a.m. a copy of Resident #3's pressure ulcer form was left on the table in the conference room. Review of the form documented, "4/28 ----Resolved---" It was signed with the nurse's name and RN (registered nurse) #1, the unit manager's name. An observation was made on 5/25/17 at 8:40 a.m. of Resident #3's feet. The skin on the right great toe was slightly reddened but intact. An interview was conducted on 5/25/17 at 8:45 a.m. with RN #1. When asked the process staff followed when a resident had a pressure ulcer, RN #1 stated, "We measure (the wound) on a weekly basis so we can see if there's any improvement or decline or if we need to change the treatment." When asked who was responsible for completing the weekly wound measurements, RN #1 stated, "The treatment nurse." When asked to speak with the nurse, RN #1 stated, "She's out on sick leave." When asked about the addition of the "resolved" documentation on 4/28/17, RN #1 stated, "I added that last night. I	F 314		

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	495394		05/25/2017

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F 314	Continued From page 54 should have put the date on there. I saw that on 4/28 in the nurse's note that is was resolved." When asked why she should have dated the note, RN #1 stated, "Why date it? Because that's when I actually wrote that." Review of the nurse's note dated 4/30/17 documented, "Late entry for 4/28/2017 Pressure area to right great toe resolved, RP (responsible party) updated. This note was created by: (name of treatment nurse) on Apr 30 2017 7:42PM." On 5/25/17 at 9:30 a.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional QA manager were made aware of the findings. Review of the facility's policy titled, "Wound and Skin Management Program" did not evidence documentation regarding how often pressure wounds were to be measured. No further information was provided prior to exit. (1)Deep tissue injury is a term proposed by NPAUP to describe a unique form of pressure ulcers. These ulcers have been described by clinicians for many years with terms such as purple pressure ulcers, ulcers that are likely to deteriorate and bruises on bony prominences (Ankrom, 2005). NPAUP's proposed definition, is "A pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise. This information was obtained from: http://www.npuap.org/wp-content/uploads/2012/01/DTI-White-Paper.pdf	F 314		
F 328	TREATMENT/CARE FOR SPECIAL NEEDS	F 328		7/8/17

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	495394		05/25/2017

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F 328 SS=D	Continued From page 55 CFR(s): 483.25(b)(2)(f)(g)(5)(h)(i)(j) (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	F 328		

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F 328	Continued From page 56 (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 care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. 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 administer oxygen per the physician order and store respiratory equipment in a sanitary manner for two of 26 residents in the survey sample, Residents #7 and #12. 1. The facility staff failed to administer Resident #7's oxygen at 2.5 LPM (liters per minute) per the physician order. Resident #7's oxygen was observed with the flow rate set at 3 LPM on separate observations during the survey. The facility staff also failed to store Resident #7's oxygen equipment in a sanitary manner, Resident #7's nasal cannula was observed lying on the floor when not in use. 2. The facility staff failed to store oxygen equipment in a sanitary manner for Resident #12.	F 328	F Tag 328: Resident #7 oxygen order was reviewed, flow rate was verified and corrected, tubing was changed and dated and a clean storage bag was obtained during the survey. No negative outcome occurred as a result of this practice. Resident #12 received a clean storage bag for oxygen tubing during survey and no negative outcomes occurred as a result. All residents receiving oxygen have the potential to be affected from this practice. The ADON/designee will educate all licensed nursing staff on Oxygen (O2) orders, maintaining O2 order settings, infection control practices on storing	

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F 328	Continued From page 57 The findings include: 1. Resident #7 was admitted to the facility on 2/22/17 with diagnoses that included but were not limited to: congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (1), urinary tract infection, chronic obstructive pulmonary disease (term used for chronic non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis (2), atrial fibrillation, high blood pressure and rheumatoid arthritis. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/30/17, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating that she was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. In Section O - Special Treatments, Procedures and Programs, Resident #7 was coded for receiving oxygen therapy. The physician order dated, 3/22/17, documented, "O2 (oxygen) 2.5 LPM (liters per minute) via NC (nasal cannula) (a device for delivering oxygen by way of two small tubes that are inserted into the nares (3))." On 5/23/17 at 2:58 p.m., Resident #7 was observed in bed. Her oxygen was on via the nasal cannula. The concentrator flow meter was	F 328	tubing and O2 equipment, and only appropriate staff adjusting O2 flow meters. The Administrative nurse team will complete an audit of O2 orders and flow rate settings for current guests with Oxygen orders to ensure appropriate settings are maintained 3xs/week for 4 weeks. The administrative team will conduct daily room audits to ensure O2 tubing and equipment are maintained and stored appropriately 5x/week for 4 weeks. Any variances will be corrected and continued education provided. Continued compliance will be monitored through the facilities quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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	495394		05/25/2017

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F 328	Continued From page 58 set with the ball sitting between the two and two and a half line. On 5/24/17 at 8:05 a.m., the resident was observed in bed. The oxygen was not on the resident. The nasal cannula was found on the floor behind the oxygen concentrator. The oxygen concentrator was running and set between two and two and a half LPM." The ball was set between the two lines. When asked if she was supposed to have oxygen, Resident #7 stated, "Yes, I need it on at all times." Resident #7 was observed on 5/24/17 at 10:44 a.m. sitting in her wheelchair. There was an oxygen tank on the back of her wheelchair. The resident was wearing the same nasal cannula that was on the floor previously. The oxygen tank was set at 3 LPM. On 5/24/17 at 1:05 p.m. Resident #7 was observed sitting in her wheelchair with the nasal cannula on and the oxygen flow meter on the oxygen tank was set at 3 LPM. The MAR (medication administration record) for May 2017 documented in part, "Oxygen: Humidified via nasal cannula; continuous for 2.5 l/min (liters per minute)." This order was dated 3/23/17. Of the 69 opportunities for documentation, there were 12 blanks on the MAR. The MAR also documented, "Respiratory daily start: 2/22/17, extended directions: 3 ltrs (liters) nasal cannula." This was documented as administered every day in May from 5/1/17 through 5/24/17. The comprehensive care plan dated, 4/13/17, documented in part, "Potential for Breathing	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 328	Continued From page 59 difficulty: R/T (related to) Asthma, End Stage COPD, heart failure." The "Approaches/Interventions" documented in part, "Administer medications and treatments per physician orders." An interview was conducted with CNA #2 on 5/24/17 at 5:02 p.m. When asked who adjusts the oxygen flow rate on oxygen concentrators, CNA #2 stated, "The nurse." When asked who adjusts the oxygen flow rate, if a resident is moved from the bed to a wheelchair and is transferred from a concentrator to a portable oxygen tank, CNA #2 stated, "Whoever transfers them, if it's me, I do. Or if it's the nurse or therapy, they adjust the rate; it's whoever does the transfer." An interview was conducted with LPN (licensed practical nurse) #4 on 5/24/17 at 5:10 p.m. LPN #4 was asked who sets the flow rate on the oxygen concentrators for residents receiving oxygen. LPN #4 stated, "The nurses." When asked who sets the flow rate on portable oxygen tanks for residents requiring oxygen, LPN #4 stated, "The nurse should." When asked if a CNA (certified nursing assistant) can adjust the oxygen, LPN #4 stated, "I am pretty sure that they can't." When asked if she walks in the room and the resident's oxygen nasal cannula is on the floor what should she do, LPN #4 stated, "Put it in the garbage and replace it." The administrators, director of nursing and regional QA (quality assurance) manager, were made aware of the above findings on 5/24/17 at 5:58 p.m.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 328	Continued From page 60 An interview was conducted with LPN #1 on 5/25/17 at 8:47 a.m. When asked who sets the rate on a resident's oxygen equipment, LPN #1 stated, "The nurses." When asked how the rate is set, LPN #1 stated, "The ball has to sit with the prescribed rate running through the center of the ball." When asked if it would be correct to have the flow meter ball is sitting between the two and two and a half line, LPN #1 stated, "No, the line has to go through the center of the ball." An interview was conducted with CNA #4 on 5/25/17 at 9:02 a.m. CNA #4 was asked who disconnects a resident from an oxygen concentrator, and reconnects them to a portable oxygen tank, when transferring from the bed to a wheelchair. CNA #4 stated, "We (the CNAs) hook it up." When asked if she sets the oxygen flow rate on the portable oxygen tank, CNA #4 stated, "Yes, we match what is on the oxygen concentrator." An interview was conducted with RN (registered nurse) #1, the unit manager, on 5/25/17 at 9:05 a.m. When asked how to read an oxygen concentrator flow rate, RN #1 stated, "I get down on one knee and look it and adjust the knob to the correct rate." When asked how the ball should be when the flow rate is set correctly, RN #1 stated, "The ball should in the center of the line of the prescribed rate." The facility policy, "Oxygen Concentrators" documented in part, "Procedure: 2. Turn concentrator on and adjust liter flow (to that ordered by physician). Listen for startup alarm. The black liter flow ball on the gauge should be position in the middle of the number line (2.0, 2.5, 3.0, 3.5) prescribed by the physician. 3. Liter Flow	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 328	Continued From page 61 should be checked by being eye level with the flow meter." According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." "The humidification system may be a source of bacteria. Pseudomonas aeruginosa is frequently the organism involved. Oxygen delivery equipment such as cannulas and masks can also harbor organisms." (Ignatavicius, D. & Workman, L. (2002) Medical Surgical Nursing, Critical Thinking for Collaborative Care, 4th edition. (p.492) Philadelphia, Pennsylvania: W. B. Saunders Company.) No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 138. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124. 2. The facility staff failed to store oxygen equipment in a sanitary manner for Resident #12. Resident #12 was admitted to the facility on 10/5/10 and readmitted on 11/3/16 with diagnoses that included but were not limited to hypertension,	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 328	Continued From page 62 dementia without behavioral disturbance, difficulty swallowing, osteoporosis, hip fracture, and stroke. Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/20/17. Resident #12 was documented as being moderately impaired in cognitive function, scoring 07 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring extensive assistance from one staff member with transfers, dressing, toileting, and personal hygiene; total dependence on one staff member with bathing, and supervision only with meals. On 5/23/17 at 3:20 p.m., an observation was made of Resident #12's room. Her oxygen tubing was observed rolled up on top of the oxygen concentrator. The tubing and nasal cannula was not stored in a plastic bag. On 5/24/17 at 7:30 a.m., an observation was made of Resident #12's room. Her oxygen tubing was observed rolled up on top of the oxygen concentrator. The tubing and nasal cannula was not stored in a plastic bag. On 5/24/17 at 12:09 p.m. an observation was made of Resident #12's room. Her oxygen tubing was observed in a plastic bag. On 5/25/17 at 9:03 a.m., an interview was conducted with LPN #8. When asked how oxygen equipment should be stored when not in use, LPN #8 stated that oxygen should be stored in a plastic bag to maintain infection control. On 5/25/17 at 9:18 a.m., an interview was conducted with LPN (licensed practical nurse) #6,	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 328	Continued From page 63 Resident #12's nurse. When asked how oxygen tubing should be stored when not in use, LPN #6 stated, "In a plastic bag." When asked why the tubing should be stored in a plastic bag, LPN #6 stated, "Infection Control." LPN #6 stated she was not aware of Resident #12's tubing being rolled up on the concentrator. LPN #6 stated she was not the nurse who put the tubing in a plastic bag. On 5/25/17 at approximately 12:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Regional QA (quality assurance) manager were made aware of the above concerns. The facility policy titled, "Oxygen Concentrators" did not address the above concerns. No further information was presented prior to exit.	F 328		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 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-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F 329		7/8/17

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	495394		05/25/2017

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F 329	Continued From page 64 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, it was determined that facility staff failed to ensure a drug regimen free from unnecessary medications for two of 26 residents in the survey sample, Resident #6 and #10. 1. The facility staff failed to obtain Resident #6's blood pressure and pulse prior to the administration of scheduled Diltiazem [1] per physicians order. 2. The facility staff failed to offer non-pharmacological interventions prior to giving	F 329	F 329 Resident #6's blood pressure and pulse is obtained prior to administration of Diltiazem and received no negative outcomes from this practice. Resident #10 has had no negative outcomes from this practice. Resident #10 is now offered non pharmacological interventions prior to receiving antianxiety medication and the effectiveness is now documented.	

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	495394		05/25/2017

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F 329	Continued From page 65 Resident #10 a medication for anxiety and failed to document the reasons the antianxiety medication was administered and its effectiveness. The findings include: 1. Resident #6 was admitted to the facility on 1/25/15 with diagnoses that included but were not limited to muscle weakness, paralysis on one side of the body post stroke, history of falls, and difficulty swallowing. Resident #6's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/27/17. Resident #6 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #6's recent POS (Physician Order Sheet) dated 4/29/17 revealed the following orders: "Diltiazem 120 MG (milligram) Tablet One TAB oral three times a daily (9:00 a.m.-pulse, sbp* (systolic blood pressure), dbp (diastolic blood pressure, 1:00 p.m.- pulse, sbp, dbp, 5:00 p.m.- pulse, sbp, dbp) PULSE: <= (less than or equal to) 59: HOLD; SBP < =110: HOLD; administer 1 tablet by mouth three times a day for hypertension (high blood pressure) hold for heart rate below 60, hold if systolic b/p (blood pressure) below 110 hypertension." Review of Resident #6's May 2017 MAR (Medication Administration Record) documented the following: "Diltiazem 120 MG Tablet One TAB oral three times a daily, oral for hypertension...Extended Directions: administer 1 tablet by mouth 3 times a day for hypertension hold for heart rate below 60, hold if systolic b/p	F 329	The DON/designee will educate all licensed nursing staff on documenting non pharmacological interventions of anxiety medications along with ensuring that the reasons for administering antianxiety medications are supported with documentation and the effectiveness of the medication is documented. The nursing administration team will complete audit checks of the medication administration records daily 5 times per week for 4 weeks and randomly thereafter to ensure that vital signs are completed, pain assessments are completed, and offering of non-pharmacological interventions are attempted prior to administration of anxiety medications. Any variances will be corrected and continued education provided. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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	495394		05/25/2017

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F 329	Continued From page 66 below 110." Further review of the MAR revealed holes or blank spaces under the vital sign section after Diltiazem was administered on the following dates and times: 5/1/17 at 9 a.m., 1 p.m., 5 p.m., 5/2/17 at 9 a.m., 1 p.m., 5 p.m., 5/3/17 at 9 a.m., 1 p.m., 5/5/17 at 5 p.m., 5/6/17 at 9 a.m., 5 p.m., 5/7/17 at 9 a.m., and 1 p.m., 5/8/17 at 9 a.m., 1 p.m., and 5 p.m., 5/10/17 at 9 a.m., 1 p.m., 5/11/17 at 9 a.m., 1 p.m., 5/12/17 at 9 a.m., 1 p.m., 5/13/17 at 9 a.m., 5 p.m., 5/14/17 at 9 a.m., 1 p.m., 5 p.m., 5/15/17 at 9 a.m., 1 p.m., 5 p.m., 5/16/17 at 9 a.m., 1 p.m., 5/17/17 at 9 a.m., 1 p.m., 5/18/17 at 9 a.m., 5 p.m., 5/19/17 at 9 a.m., 5/20/17 at 1 p.m., 5 p.m., 5/21/17 at 9 a.m., 1 p.m., 5 p.m., 5/22/17 at 9 a.m., 1 p.m., 5/23/17 at 5 p.m., 5/24/16 at 9 a.m., 1:00 p.m. Review of the nursing notes failed to reveal blood pressure and pulse readings documented prior to administration of Diltiazem. On 5/25/17 at 9:15 a.m., an interview was conducted with LPN (licensed practical nurse) #6, Resident #6's nurse and the nurse who administered Diltiazem on several occasions. When asked about the process followed prior to	F 329		

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	495394		05/25/2017

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F 329	Continued From page 67 administering blood pressure medication with physician ordered parameters, LPN #6 stated that she would take the resident's blood pressure and pulse prior to administering the medication. LPN #6 stated that she would hold the medication if the blood pressure or pulse were below the ordered parameters. When asked if the blood pressure and pulse should be documented, LPN #6 stated, "Yes." When asked where the blood pressure and pulse would be documented, LPN #6 stated that it would be documented on the MAR after the readings are typed into the EMAR (electronic medication administration record). LPN #6 viewed Resident #6's May MAR and confirmed the vital sign section for the administration of Diltiazem was blank for the above dates. LPN #6 stated that she always checks the blood pressure and pulse. LPN #6 stated that she documented recordings on the 24 hour shift report. When asked if this was part of the clinical record, LPN #6 stated, "No." When asked how a nurse or physician would know what the resident's previous blood pressure recordings were, LPN #6 stated that nursing staff and the physician could look at the 24 hour report. LPN #6 stated, "I'll see if I can dig them up." LPN #6 stated that the blood pressure and pulse for Resident #6 should have been documented in the clinical record. On 5/25/17 at approximately 10:00 a.m. a copy of the 24 hour report was presented to this surveyor. Review of the 24 hour report revealed the following vital signs documented in May 2017 for Resident #6: - 5/1/17, 7-3 a.m. shift: "137/78 (blood pressure)." A pulse was not documented. There	F 329		

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	495394		05/25/2017

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F 329	Continued From page 68 was no indication that this blood pressure reading was for 9 a.m. or 1 p.m. Vital signs were not documented for 3-11 shift. - 5/2/17, 7-3 a.m. shift: "130/77." A pulse was not documented. There was no indication that this blood pressure reading was for 9 a.m. or 1 p.m. Vital signs were not documented on the 24 hour report for 3-11 shift. - 5/3/17, 7-3 a.m. shift: "129/74." A pulse was not documented. There was no indication that this blood pressure reading was for 9 a.m. or 1 p.m. - 5/5/17, 3-11 shift: Vital signs were not documented on the 24- hour report. - 5/6/17, 7-3 a.m. shift: "123/71." A pulse was not documented. Vital signs were not documented for 3-11 shift. - 5/7/17, 7-3 a.m., shift: "121/66." A pulse was not documented. There was no indication that this blood pressure reading was for 9 a.m. or 1 p.m. - 5/8/17, 7-3 a.m., shift: "146/79." A pulse was not documented. There was no indication that this reading was for 9 a.m. or 1 p.m. Vital signs for 3-11 shift were not documented. - 5/10/17, 7-3 shift: "120/79." A pulse was not documented. There was no indication that this reading was for 9 a.m. or 1 p.m. - 5/12/17, 7-3 shift: "130/74." A pulse was not documented. There was no indication that this reading was for 9 a.m. or 1 p.m. - 5/13/17, 3-11 shift: Vital signs were not	F 329		

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	495394		05/25/2017

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F 329	Continued From page 69 documented on the 24 hour report. Further Review of the 24 hour report revealed that there were no sheets or vital signs documented for 5/11/17 and 5/14/17 through 5/24/17. On 5/25/17 at approximately 12:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Regional QA (quality assurance) manager were made aware of the above findings. No further information was presented prior to exit. [1] Diltiazem- used alone or in conjunction with other medicines to treat angina (severe chest pain), or high blood pressure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009954/?report=details. *Blood pressure is a measurement of the force applied to the walls of the arteries as the heart pumps blood through the body. The pressure is determined by the force and amount of blood pumped, and the size and flexibility of the arteries. Blood pressure readings are measured in millimeters of mercury (mmHg) and are given as two numbers, for example, 110 over 70 (written as 110/70). The top number is the systolic blood pressure reading. It represents the maximum pressure exerted when the heart contracts. The bottom number is the diastolic blood pressure reading. It represents the minimum pressure in the arteries when the heart is at rest. The information above was obtained	F 329		

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F 329	Continued From page 70 from the web site: <http://www.nlm.nih.gov/medlineplus/ency/article/003398.htm> 2. The facility staff failed to offer non-pharmacological interventions prior to giving Resident #10 a medication for anxiety and failed to document the reasons the antianxiety medication was administered and its effectiveness. Resident #10 was admitted to the facility on 11/13/15 with diagnoses that included but were not limited to: thyroid disorder, Alzheimer's disease, high blood pressure, and dementia with behavioral disturbances. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/9/17 coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score indicating that she was severely impaired to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living, except eating in which she was coded as requiring supervision after set up assistance was provided. The physician order dated, 12/15/16, documented, "Vistaril (hydroxyzine - used to treat anxiety, nausea, vomiting, allergies, skin rashes (1)) 25 MG (milligrams) Capsule; one cap (capsule) oral every 6 hours prn (as needed) anxiety." Review of the eMAR (electronic medical record) for March 2017 documented, "Vistaril 25 MG	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 329	Continued From page 71 Capsule; one cap oral every 6 hours prn anxiety." The medication was administered on 3/2/17, 3/7/17, 3/11/17, 3/29/17, 3/30/17 and 3/31/17. The eMAR notes documented the following: 3/2/17 at 3:44 p.m. Autocreated note: Pre Documentation for PRN. Reason: Anxiety. 3/2/17 at 4:24 p.m. Autocreated note: Post documentation for PRN: Effective - yes." 3/7/17 at 11:09 p.m. 3/7/17 - 11:51 p.m. -Autocreated note: Post documentation for PRN: Effective - yes." Autocreated note: Pre Documentation for PRN. Reason: Anxiety. There was no other documentation as to why the medication was administered and if it was effective. The nurse's notes for 3/2/17 at 3:47 p.m. documented, "Autocreated note: Pre Documentation for PRN. Reason: Anxiety. The nurse's note dated, 3/2/17 at 4:25 p.m., documented, "Autocreated note: Post documentation for PRN: Effective - yes." The nurse's note 3/7/17 at 11:10 p.m. documented, "Autocreated note: Pre Documentation for PRN. Reason: Anxiety." The nurse's note dated, 3/7/17 at 11:52 p.m. documented, "Autocreated note: Post documentation for PRN: Effective - yes." There was no documentation for any of the other dates the resident received the medication. There was no documentation for any of the doses administered in March 2017 and no documentation of non-pharmacological interventions provided or attempted prior to administering the Vistaril. Review of the eMAR for April 2017 documented, "Vistaril 25 MG Capsule; one cap oral every 6 hours prn anxiety." The medication was administered on 4/5/17, 4/8/17, 4/10/17, 4/12/17, 4/13/17, 4/17/17, 4/20/17, 4/21/17, 4/22/17 and	F 329		

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F 329	Continued From page 72 4/24/17. The eMAR notes documented the following: 4/21/17 at 10:04 a.m., Autocreated note: Pre Documentation for PRN. Reason: for noted anxiety following am (morning) activities." The eMAR note dated, 4/21/17 at 12:01 p.m. documented, "Autocreated note: Post documentation for PRN: Effective - yes." There were no other eMAR notes related to the administration of the Vistaril. The nurse's note for 4/21/17 at 10:04 a.m. documented, " Autocreated note: Pre Documentation for PRN. Reason: for noted anxiety following am (morning) activities." The nurse's note dated, 4/21/17 at 12:01 p.m. documented, "Autocreated note: Post documentation for PRN: Effective - yes." There was no further documentation in the nurse's notes for April 2017 that evidenced non-pharmacological interventions were attempted and no documentation for the effectiveness of the Vistaril that was administered. The May 2017 eMAR documented, "Vistaril 25 MG Capsule; one cap oral every 6 hours prn anxiety." The medication was administered on 5/2/17, 5/3/17, 5/4/17, 5/16/17 and 5/17/17. The eMAR notes dated 5/2/17 at 8:46 a.m. documented, "Autocreated note: Pre Documentation for PRN. Reason: increase in anxiety." The eMAR note dated, 5/4/17 at 7:37 p.m. documented, "Autocreated note: Pre Documentation for PRN. Reason: anxious." The eMAR note dated, 5/4/17 at 10:00 p.m. documented, "Autocreated note: Post documentation for PRN: Effective - yes." There was no further documentation as to the reasons Resident #10 received the Vistaril on the other	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 329	Continued From page 73 dates. Review of the nurse's notes for 5/2/17 at 8:47 a.m. documented, "Autocreated note: Pre Documentation for PRN. Reason: increase in anxiety." The nurse's note dated, 5/4/17 at 7:38 p.m. documented, "Autocreated note: Pre Documentation for PRN. Reason: anxious." The nurse's note dated, 5/4/17 at 10:00 p.m. documented, "Autocreated note: Post documentation for PRN: Effective - yes." There was no documentation in the nurse's note for the month of May 2017 that evidenced non-pharmacological interventions offered prior to administering the Vistaril and no documentation of the effectiveness after the administration of the Vistaril. The comprehensive care plan, dated, 5/23/17 documented, "Problems: Falls: At risk for fall related injury related to impaired mobility, psychotropic drug use and history of falls." The "Approaches/Interventions" documented in part, "Administer medications per physician orders. Observe for ineffectiveness and side effects, report abnormal findings to the physician. Problems: Actual Behavior Problem: Guest has pulled fire alarm once, has periods of wondering (sic) and can be combative with CNAs (certified nursing assistants) during care." The "Approaches/Interventions" documented in part, "Administer medications and monitor effects. If unable to redirect behavior, assist guest to a quiet location. Encourage diversional activity. Problems: At risk for mood issues with history of restlessness, crying, sad facial expressions and diagnosis of depression." The "Approaches/Interventions" documented in part, "Attempt diversional activities when having mood	F 329		

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	495394		05/25/2017

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F 329	Continued From page 74 issues. If signs of restlessness, crying or withdrawal approach in calm reassuring manner and attempt to interact with guest. Staff to redirect as needed." An interview was conducted with LPN (licensed practical nurse) #1, on 5/24/17 at 1:20 p.m. When asked what staff should do if a resident is displaying signs of anxiety or anxious behaviors, LPN #1 stated, "First you assess the resident. Check their vital signs. Check to see if they are in pain. You should try to calm them down with deep breathing. Possibly find out the cause of the anxiety and remove it. Redirect the resident. Then notify the doctor." When asked about the process followed by staff prior to administering PRN medications for anxiety, LPN #1 stated, "I would give it. When asked if staff document the things tried before the medication is administered, LPN #1 stated, "Yes, we should write a note in the nurse's notes of what we tried. Whenever we give a PRN medication we have to check the effectiveness and document it on the MAR." An interview was conducted with RN (registered nurse) #1, the unit manager, on 5/24/17 at 1:20 p.m. When asked about the process staff follows for a resident is displaying signs of anxiety or anxious behaviors, RN #1 stated, "First you try to redirect, maybe get them in activities. The nurse can check to see if they have any medication ordered for anxiety and administer it or call the doctor." When asked where the staff document the intervention attempted prior to administering the PRN medications, RN #1 stated, "You should put a note in the nurse's notes." When asked where the reason for administering the medication and the effectiveness of the PRN	F 329		

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	495394		05/25/2017

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F 329	Continued From page 75 medication is documented, RN #1 stated, "It's in the eMAR notes." An interview was conducted with LPN #4 on 5/24/17 at 5:15 p.m. LPN #4 is Resident #10's normal evening shift nurse. LPN #4 was asked what she does when Resident #10 is displaying anxious behaviors or anxiety, LPN #4 stated, "I check the orders and give her medication." When asked where the reason for administering the medication is documented, LPN #4 stated, "It's on the eMAR." When asked if she tries anything prior to giving the medication, LPN #4 stated, "Sometimes." When asked where what she has tried is documented, LPN #4 stated, "We chart that in the nurse's notes." The facility policy, "Medication Administration" documented in part, "12. Record all PRN medications on the guest's Medication Administration Record (MAR) including date, time and effectiveness." The administrator, director of nursing and administrative staff member (ASM) # 3, regional QA (quality assurance) manager, were made aware of the above findings on 5/24/17 at 5:58 p.m. A request was made to ASM #3 on 5/25/17 at 10:15 a.m. for a policy on administering PRN anti-anxiety medications and offering non-pharmacological interventions. On 5/25/17 at 11:40 a.m. ASM #3 stated the facility did not have a specific policy on non-pharmacological interventions. (1) This information was obtained from the	F 329		

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F 329	Continued From page 76 following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0023966/?report=details	F 329		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (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 from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document, it was determined that the facility staff failed to ensure food was prepared, and stored in a sanitary manner.	F 371	F 371 The oven has been cleaned. The biscuits were labeled and dated. The gasket to the refrigerator door was cleaned. The	7/8/17

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F 371	Continued From page 77 1. The ovens were found with black crusted debris on the surface of the oven floor. 2. A bag of biscuits was not labeled or dated in the freezer. 3. The gasket of the door to the refrigerator was covered with a black deposit along the edge. 4. A container of Ricotta cheese was dated as opened on 4/1/17 and was available for use on 5/23/17. 5. The facility staff failed to maintain the kitchen ice machine drain in a sanitary manner. The findings include: 1. Observation was made of the kitchen on 5/23/17 at 11:00 a.m. accompanied by other staff member (OSM) #6, the head cook. The ovens under the stove were observed. The right oven had a moderate amount of black crusted debris in the bottom. When asked when the ovens were last used, OSM #6 stated, "They were used yesterday and they didn't clean them out afterwards." When asked how often they are cleaned, OSM #6 stated, "If you see a spill or overflow of food on the bottom you are supposed to clean it up after each use. The ovens are cleaned weekly." An interview was conducted with OSM #5, the dietary manager, on 5/24/17 at 5:37 p.m. When asked how often the ovens are to be cleaned, OSM #5 stated, "They are cleaned weekly and if you see black stuff they should wipe it off when they see it." The facility policy, "Ovens - Conventional and Convection" documented in part, "Policy: All ovens shall be cleaned as at least once a week and as needed. Procedure: 1. Allow oven to cool.	F 371	container of ricotta cheese was discarded. The kitchen ice machine drain was been shortened according to code. All guests have the potential to be affected by these deficient practices. The Dietary Manager will inspect the oven for cleanliness weekly. An audit of the food products in the freezer was completed and all unlabeled food was dated according to policy. An audit of the food products in the refrigerator was completed and no other products with a limited shelf life were found. An inspection of all facility ice machine drain pipes was completed and all were within code. Dietary staff will be in-serviced by the Dietary Manager regarding weekly and as needed cleaning of the oven, proper labeling of all opened food products, cleaning of the refrigerator gasket as needed, and disposal of limited shelf life food products according to company policy. Administrator will in-service the Director of Maintenance on maintaining facility ice machine drain pipes. Dietary Manager or designee will review cleanliness of the oven, refrigerator gasket, labeling of opened food products, disposal of limited shelf life foods and facility ice machine drain pipes once per week for 4 weeks. Variances will be reported by the Dietary Manager or Director of Maintenance to QA committee for trending and analysis.	

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F 371	Continued From page 78 2. Remove shelves, take to pot and pan sink and scrub, or run through dish machine. 3. Rinse. 4. Sanitize all shelves. 5. Scrape burned on particles from bottom of oven. 6. Brush interior shelf ledges and door crevices. 7. Scrub interior, shelf ledges, inside and outside of oven with long rubber gloves, goggles, oven cleaner and scouring pad. 8. Rinse thoroughly inside and outside of oven with clean hot water and clean cloth. 9. Replace clean shelf. 10. Polish metal trim with clean dry cloth." 2. Observation was made of the freezer on 5/23/17 at 11:00 a.m. A plastic bag, of what appeared to be biscuits, was found tied up with no label or date, sitting on top of a box on the freezer shelf. When asked what was in the bag, OSM #6 stated, "That's the biscuits that they used today." When asked if it was supposed to have a label and date on it, OSM #6 stated, "Yes." She looked on the floor and shelves below where the bag was to see if a label had been there and fallen off but none was found. An interview was conducted with OSM #5, the dietary manager, on 5/24/17 at 5:37 p.m. When asked how food is labeled once it's opened, OSM #5 stated, "Once it is opened the staff is to close it up tightly and put a sticker on it as to when it was opened and what it is." The facility policy, "Frozen Storage" documented in part, "3. All froze products shall be labeled indicating product name and date of delivery (month, day and year)." 3. Observation was made of the refrigerator on 5/23/17 at 11:00 a.m. The gasket around the door had a black substance all along the edges of	F 371		

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F 371	Continued From page 79 the door. When asked how often the gaskets get washed, OSM #6 stated, "Every three months." An interview was conducted with OSM #5, the dietary manager, on 5/24/17 at 5:37 p.m. When asked how often the gaskets on the refrigerators are cleaned, OSM #5 stated, "They should be cleaned once a month." The facility policy, "Freezer, Walk-In" documented in part, "9. Wash gaskets, use a brush if needed, and replace when necessary.....Note: Check all gaskets thoroughly." 4. Observation was made of the refrigerator on 5/23/17 at 11:00 a.m. A 48 ounce container of Ricotta Cheese was found to be opened and dated, 4/1/17. The "use by" date was dated 6/10/17. When asked how long Ricotta cheese is good for once opened, OSM #6 could not answer the question and stated that she would get back with me. She never returned to this surveyor with the information requested. An interview was conducted with OSM #5, the dietary manager, on 5/24/17 at 5:37 p.m. When asked how long Ricotta cheese is good for once opened, OSM #5 stated, "Our policy is to discard it two weeks after opening. It's a soft cheese so it has a shorter shelf life." The facility policy, "Storage of Food" documented in part, "Product: Cottage cheese, Ricotta. Refrigerated: 1 week." 5. The facility staff failed to maintain the kitchen ice machine drain in a sanitary manner.	F 371		

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F 371	Continued From page 80 Observation was made of the kitchen on 5/23/17 at 11:00 a.m. with other staff member (OSM) #6, the head cook. The ice machine in the kitchen was observed. The drain pipe was below the surface of the floor drain. The drain pipe was observed to be next to the back edge of the drain. The drain had a black substance around the edges where the pipe was hitting. A pepper shaker, butter packet and other debris were observed in the drain. When asked how far off the floor drain should the drain pipe be located, OSM #6 stated, "I don't know, (name of maintenance director) handles that." On 5/23/17 at 12:40 p.m. OSM #3, the director of maintenance, came to the kitchen with this surveyor. OSM #3 was shown the floor drain and ice machine drain pipe. When asked how far above the floor drain the ice machine drain pipe should be, OSM #3 stated, "It should be one inch above." When asked if the pipe was currently one inch above the drain, OSM #3 stated, "No, Ma'am." When asked if the drain, in its current state was up to code, OSM #3 stated, "No." OSM #3 verified the presence of other debris in the drain. On 5/24/17 at 11:22 a.m. the ice machine drain was observed. The ice machine drain was above the surface of the drain and all of the debris and black substance had been cleaned out of the drain. The facility documented entitled, "Water-Cooled Condenser" documented in part, "Separate piping to approve drain. Leave a two-inch (5 cm [centimeters]) vertical air gap between the end of each pipe and the drain."	F 371		

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F 371	Continued From page 81 The administrator, director of nursing and regional QA (quality assurance) manager, were made aware of the above findings on 5/24/17 at 5:58 p.m. No further information was provided prior to exit.	F 371		
F 387 SS=D	FREQUENCY & TIMELINESS OF PHYSICIAN VISIT CFR(s): 483.30(c)(1)(2) (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that facility staff failed to ensure timely physician visits for one of 26 residents in the survey sample, Resident #6. The facility staff failed to ensure Resident #6 received a physician visit between 11/15/16 and 3/14/17 (117 days). The findings include: Resident #6 was admitted to the facility on 1/25/15 with diagnoses that included but were not limited to muscle weakness, paralysis on one	F 387	F Tag 387: Resident #6 received no harm from this practice and is now receiving visits in a timely manner. The DON/designee will educate medical records clerk on physician visits occurring at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The medical records clerk will audit all current records for the past 6 months to ensure timely visits by the physician.	7/8/17

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F 387	Continued From page 82 side of the body post stroke, history of falls, and difficulty swallowing. Resident #6's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/27/17. Resident #6 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #6's clinical record revealed that Resident #6 was seen by the physician for recertification on 11/15/16. The next physician visit found in the clinical record was dated 3/14/17. Physician visits between these dates could not be found in the clinical record. On 5/25/17 at 11:44 a.m., ASM (administrative staff member) #3, the Regional QA (quality assurance) manager stated, "We don't have them." When asked who was responsible for ensuring physician visits, ASM #3 stated, "Medical Records." On 5/25/17 at 11:54 a.m., an interview was conducted with OSM (other staff member) #8, medical records. When asked about the process followed for ensuring physician visits, OSM #8 stated that every month she will conduct an audit and review all charts on the unit to see which residents need a physician's visit for recertification. OSM #8 stated that she will alert the physician and NP (nurse practitioner) of all residents who need a recertification visit. OSM #8 stated that the physician receives a list of residents that need to be seen. OSM #8 stated that once the physician visits the resident, the physician will send a typed report to medical records and she will then file the report in the clinical record. OSM #8 stated that she was	F 387	The medical records clerk will maintain a tickler system to ensure all visits by the physician are timely for the next 3 months and thereafter. The medical records clerk will notify physicians from this system if visit is due. The medical records clerk will communicate results of these audits to the DON so she can report the results to the QA committee. Continued compliance will be monitored through the facilities quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 387	Continued From page 83 certain the physician saw Resident #6 between 11/15/16 and 3/14/17. OSM #8 stated that she could not find the visit. On 5/25/17 at approximately 12:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3 were made aware of the above concerns. The facility policy titled, "Physician Visit Schedule" documented in part, the following: "Policy: All guests admitted to the facility shall be under the direct supervision of a physician. Each physician who has staff privileges shall be responsible for the designation of an alternate physician to care for his/her guest when he/she is not available. All guests shall be seen and evaluated by the responsible physician at least once every 30 days for the first 90 days of stay. After this time, an alternate visit schedule may be established according to state and federal regulation. Guest must be seen at least once every 60 days after the first 90 days of stay. At the option of the physician, required visits after the first initial visit may alternate between the physician and a designee, Nurse Practitioner or Physician Assistant, in accordance with the Medical Practice Act of the State in which the facility is located." No further information was provided by completion of the survey.	F 387		
F 504 SS=D	LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN CFR(s): 483.50(a)(2)(i) (a) Laboratory Services	F 504		7/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 504	Continued From page 84 (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. 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 obtain a physician order prior to obtaining a laboratory test for two of 26 residents in the survey sample, Resident #9 and Resident #10. 1. The facility staff failed to obtain a physician order prior to obtaining a Dilantin level for Resident #9. 2. The facility staff failed to obtain a physician order prior to obtaining a TSH (thyroid stimulating hormone (1)) on 3/18/17 and a BMP (basic metabolic panel (2)), CBC (complete blood count (2)) and TSH on 12/15/16 for Resident #10. The findings include: 1. Resident #9 was admitted to the facility on 2/8/17 with diagnoses that included but were not limited to: debility, dementia, atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular eats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (1)), seizure disorder, chronic obstructive pulmonary disease (COPD - general term for chronic nonreversible lung	F 504	F Tag 504: The physician was notified of both Resident #9 and Resident #10 having labs obtained without physician order. The responsible parties of both residents were also contacted regarding the labs being obtained. Resident #9 and Resident #10 received no harm from this practice. All residents have the potential to be affected by this practice. The ADON/designee will educate all licensed nursing staff on obtaining laboratory services only when ordered by a physician. The Administrative Nursing Team will review and track all lab orders received and results received daily 5x/week for 4 weeks to ensure labs are obtained per physician orders. Any variances identified will be corrected and continued education provided. Continued compliance will be monitored through the facilities quality assurance program. Additional education and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 504	Continued From page 85 disease that is a combination of emphysema and chronic bronchitis, and altered mental status (2)) and altered mental status. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/23/17, coded the resident as scoring an "8" on the BIMS (brief interview for mental status) indicating that he was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of his activities of daily living except eating in which he only required supervision after set up assistance was provided. The clinical record was reviewed on 5/23/17. A copy of a laboratory result for a Dilantin Level (Dilantin is a drug used to treat seizures, the Dilantin level measures the therapeutic level of the drug in the blood stream (3)); dated 5/1/17 was found on the clinical record. The comprehensive care plan, dated, 2/22/17, documented in part, "Problem: At risk for seizure activity related to history of seizure disorder." The "Approaches/Interventions" documented in part, "Obtain labs/diagnostics as ordered and report abnormal to MD (medical doctor)." On 5/24/17 at 5:58 p.m., the physician order for the Dilantin level obtained 5/1/17 was requested from the administrator, (administrative staff member [ASM] #1) director of nursing, ASM #2 and regional QA (quality assurance) manager, ASM #3. ASM #1, ASM #2 and ASM #3 were informed of the concern regarding no physician's order for the above laboratory (lab) test.	F 504	monitoring will be initiated for any identified concerns.	

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F 504	Continued From page 86 On 5/25/17 at 9:00 a.m., RN (registered nurse) #1, the unit manager, informed this surveyor that they had not been able to locate the orders for the above lab work. When asked if you need a physician's order to perform laboratory tests, RN #1 stated, "Yes, we can't do one without it." The facility policy, "Lab (laboratory) Test Scheduling System" documented in part, "Procedure: 1. Obtain physician's order for lab test." No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 55. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 124. (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011722/?report=details 2. The facility staff failed to obtain a physician order prior to obtaining a TSH (thyroid stimulating hormone (1)) on 3/18/17 and a BMP (basic metabolic panel (2)), CBC (complete blood count (2)) and TSH on 12/15/16 for Resident #10. Resident #10 was admitted to the facility on 11/13/15 with diagnoses that included but were not limited to: thyroid disorder, Alzheimer's disease, high blood pressure, and dementia with behavioral disturbances.	F 504		

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F 504	Continued From page 87 The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/9/17 coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score indicating that she was severely impaired to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living, except eating in which she was coded as requiring supervision after set up assistance was provided. The clinical record was reviewed on 5/23/17. A copy of a laboratory test results with a test for a TSH (thyroid stimulating hormone (1)) was dated 3/18/17. A copy of a laboratory test results for a CBC (complete blood count (2)), BMP (basic metabolic panel (3)), and a TSH was dated 12/15/16. The comprehensive care plan dated, 5/23/17, documented in part, "Problem: Potential for complications related to hypothyroidism, i.e. intolerance to cold, decreased appetite, weight gain, dry skin, mood changes, constipation fatigue, bradycardia." The "Approaches/Interventions" documented in part, "Labs and diagnostic as ordered." On 5/24/17 at 5:58 p.m. at the end of the day meeting the physician orders for the laboratory tests above were requested from ASM #1, ASM #2 and ASM #3. ASM #1, ASM #2 and ASM #3 were informed of the concern, regarding no physician orders for the above laboratory (lab) test results. On 5/25/17 at 9:00a.m., RN (registered nurse)	F 504		

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	495394		05/25/2017

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F 504	Continued From page 88 #1, the unit manager, informed this surveyor that they had not been able to locate the orders for the above lab work. When asked if a physician order is needed to perform a laboratory tests, RN #1 stated, "Yes, we can't do one without it." No further information was provided prior to exit. (1) This information was obtained from the following website: https://wwwqa.nlm.nih.gov/medlineplus/275/ency/article/003684.htm (2) This information was obtained from the website: https://medlineplus.gov/bloodcounttests.html (3) This information was obtained from the website: http://www.nlm.nih.gov/medlineplus/ency/article/003462.htm	F 504		
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 514		7/8/17

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	495394		05/25/2017

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F 514	Continued From page 89 (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, it was determined that facility staff failed to maintain a complete and accurate clinical record for four out of 26 residents in the survey sample, Resident #6, 12, 5, and 4. 1. The facility staff failed to document Resident #6's vital signs prior to the administration of Diltiazem [1] on 5/12/17 at 9:00 a.m. 2. The facility staff failed to document a pain assessment prior to the administration of PRN (as needed) pain medications to Resident #12. 3 a. The facility staff failed to document Resident #5's transfer to the hospital from an endocrinology appointment on 5/16/17.	F 514	F Tag 514: Resident #6's vital signs are collected prior to administration of Diltiazem. Resident #12 is having pain assessments completed prior to receiving PRN pain medications. Resident #5 has had no negative impact from the practice of not documenting in the chart a transfer to the hospital from an appointment and is now having documentation completed of non-pharmacological interventions prior to administration of Tramadol. Resident #4's physician was notified of	

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	495394		05/25/2017

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F 514	Continued From page 90 3 b. The facility staff failed to document non-pharmacological interventions attempted prior to the administration of Tramadol [1] to Resident #5. 4. The facility staff failed to document treatments on the May 2017 MAR (medication administration record) and TAR (treatment administration record) for Resident #4. The findings include: 1. Resident #6 was admitted to the facility on 1/25/15 with diagnoses that included but were not limited to muscle weakness, paralysis on one side of the body post stroke, history of falls, and difficulty swallowing. Resident #6's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/27/17. Resident #6 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #6's recent POS (Physician Order Sheet) dated 4/29/17 revealed the following orders: "Diltiazem 120 MG (milligram) Tablet One TAB oral three times a daily (9:00 a.m.-pulse, sbp* (systolic blood pressure), dbp (diastolic blood pressure, 1:00 p.m.- pulse, sbp, dbp, 5:00 p.m.- pulse, sbp, dbp) PULSE: <= (less than or equal to) 59: HOLD; SBP < =110: HOLD; administer 1 tablet by mouth three times a day for hypertension (high blood pressure) hold for heart rate below 60, hold if systolic b/p (blood pressure)	F 514	the omissions in both the MAR and TAR along with notification to the responsible party. The resident received no negative outcomes due to this practice. All residents have the potential to be affected by these practices. The ADON/designee will educate all licensed nursing staff on obtaining vital signs prior to the administration of Diltiazem, documenting a pain assessment prior to administration of a PRN pain medication, documentation completion when a resident discharges from the facility, and documentation of non-pharmacological interventions prior to administration of pain medications along with the 5 rights of medication administration with a focus on documenting medications and treatments on the administration records. The Nursing Administration Team will complete audit checks of the medication administration records daily 5x/week for 4 weeks and randomly thereafter to ensure that vital signs are completed, pain assessments are completed, and offering of non-pharmacological interventions are attempted prior to administration of pain medications and that there are no omissions in the medication record and treatment record. Any variances will be corrected and continued education provided. The Nursing Administration Team will	

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	495394		05/25/2017

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F 514	Continued From page 91 below 110 hypertension." Review of Resident #6's May 2017 MAR (Medication Administration Record) documented the following: "Diltiazem 120 MG Tablet One TAB oral three times a daily, oral for hypertension...Extended Directions: administer 1 tablet by mouth 3 times a day for hypertension hold for heart rate below 60, hold if systolic b/p below 110. Further review of the MAR revealed holes or blank spaces under the vital sign section after Diltiazem was administered on the following dates and times: 5/1/17 at 9 a.m., 1 p.m., 5 p.m., 5/2/17 at 9 a.m., 1 p.m., 5 p.m., 5/3/17 at 9 a.m., 1 p.m., 5/5/17 at 5 p.m., 5/6/17 at 9 a.m., 5 p.m., 5/7/17 at 9 a.m., and 1 p.m., 5/8/17 at 9 a.m., 1 p.m., and 5 p.m., 5/10/17 at 9 a.m., 1 p.m., 5/11/17 at 9 a.m., 1 p.m., 5/12/17 at 9 a.m., 1 p.m., 5/13/17 at 9 a.m., 5 p.m., 5/14/17 at 9 a.m., 1 p.m., 5 p.m., 5/15/17 at 9 a.m., 1 p.m., 5 p.m., 5/16/17 at 9 a.m., 1 p.m., 5/17/17 at 9 a.m., 1 p.m., 5/18/17 at 9 a.m., 5 p.m., 5/19/17 at 9 a.m., 5/20/17 at 1 p.m., 5 p.m., 5/21/17 at 9 a.m., 1 p.m., 5 p.m., 5/22/17 at 9 a.m., 1 p.m., 5/23/17 at 5 p.m., 5/24/16 at 9 a.m., 1:00 p.m.	F 514	review discharge documentation daily 5x/week for 4 weeks and randomly thereafter of all residents discharging from facility. Any variances will be corrected and continued education will be provided. Continued compliance will be monitored through the facilities quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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	495394		05/25/2017

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F 514	Continued From page 92 Review of the May 2017 nursing notes failed to reveal blood pressure and pulse readings documented prior to the administration of Diltiazem. On 5/25/17 at 9:15 a.m., an interview was conducted with LPN (licensed practical nurse) #6, Resident #6's nurse and the nurse who administered Diltiazem on several occasions. When asked about the process followed prior to administering blood pressure medication with physician ordered parameters, LPN #6 stated that she would take the resident's blood pressure and pulse prior to administering the medication. LPN #6 stated that she would hold the medication if the blood pressure or pulse were below the ordered parameters. When asked if the blood pressure and pulse should be documented, LPN #6 stated, "Yes." When asked where the blood pressure and pulse would be documented, LPN #6 stated that it would be documented on the MAR after the readings are typed into the EMAR (electronic medication administration record). LPN #6 viewed Resident #6's May MAR and confirmed the vital sign section for the administration of Diltiazem was blank for the above dates. LPN #6 stated that she always checks the blood pressure and pulse. LPN #6 stated that she documented recordings on the 24 hour shift report. When asked if this was part of the clinical record, LPN #6 stated, "No." When asked how a nurse or physician would know what the resident's previous blood pressure recordings were, LPN #6 stated that nursing staff and the physician could look at the 24 hour report. LPN #6 stated, "I'll see if I can dig them up." LPN #6 stated that the blood pressure and pulse for Resident #6 should have been documented in the clinical record.	F 514		

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	495394		05/25/2017

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F 514	Continued From page 93 On 5/25/17 at approximately 10:00 a.m. a copy of the 24 hour report was presented to this surveyor. Review of the 24 hour report revealed that vital signs were documented for 9 a.m. on 5/13/17. The following was documented: "174/78 (blood pressure), 78 (pulse)." All other vital signs documented on the 24 hour report could not be correlated with the above administration times of Diltiazem. On 5/25/17 at approximately 12:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Regional QA (quality assurance) manager were made aware of the above findings. Facility policy titled, "Documentation" documents in part, the following: "Documentation in a guest's medical record is done to reflect a guest's status as well as address acute episodes. Interventions taken, the guest's response to interventions, and any unusual occurrences should also be recorded. Documentation is also done to describe any educational instruction which is given to the guest and/or responsible party." Potter-Perry Fundamentals of Nursing, 6th edition contains a quotation on page 477 regarding documentation as follows: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of	F 514		

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	495394		05/25/2017

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F 514	Continued From page 94 nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to clients. Effective documentation ensures continuity of care, saves time, and minimizes the risks of errors." [1] Diltiazem- used alone or in conjunction with other medicines to treat angina (severe chest pain), or high blood pressure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009954/?report=details. *Blood pressure is a measurement of the force applied to the walls of the arteries as the heart pumps blood through the body. The pressure is determined by the force and amount of blood pumped, and the size and flexibility of the arteries. Blood pressure readings are measured in millimeters of mercury (mmHg) and are given as two numbers, for example, 110 over 70 (written as 110/70). The top number is the systolic blood pressure reading. It represents the maximum pressure exerted when the heart contracts. The bottom number is the diastolic blood pressure reading. It represents the minimum pressure in the arteries when the heart is at rest. The information above was obtained from the web site: <http://www.nlm.nih.gov/medlineplus/ency/article/003398.htm> 2. The facility staff failed to document a pain assessment prior to the administration of PRN (as needed) pain medications to Resident #12. Resident #12 was admitted to the facility on	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 95 10/5/10 and readmitted on 11/3/16 with diagnoses that included but were not limited to hypertension, dementia without behavioral disturbance, difficulty swallowing, osteoporosis, hip fracture, and stroke. Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/20/17. Resident #12 was documented as being moderately impaired in cognitive function, scoring 07 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring extensive assistance from one staff member with transfers, dressing, toileting, and personal hygiene; total dependence on one staff member with bathing, and supervision only with meals. Review of Resident #12's most recent POS (physician order sheet) documented the following order: "Hydrocodone-Acetaminophen 325 mg (milligrams) [1] one tab p.o. (by mouth) q (every) 6 hour prn (as needed) pain." This order was initiated on 11/3/16. Review of Resident #12's April and March 2017 MAR (Medication Administration Record) documented the following: "Hydrocodone-Acetaminophen 5-325 one tab every 6 hour prn, oral for pain." Further Review of Resident #12's April 2017 MAR revealed that she received Hydrocodone-Acetaminophen on 4/22/17 at 7:39 p.m. The following was documented: "4-22-17 07:39 PM by (Name of nurse): Auto created note: Pain Level Dialog box was canceled by user at 07:39 PM when medication was administered." Further Review of Resident #12's March 2017	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 96 MAR revealed that she received Hydrocodone-Acetaminophen on 3/21/17 at 9:58 p.m. and 3/22/17 at 10:27 p.m. The following was documented: "03-21-17 09:58 PM by (Name of Nurse) Auto created note: Pain Level Dialog was canceled by user at 09:58 PM when medication was administered. 03-22-17 10:27 PM by (Name of Nurse) Auto created note: Pain Level Dialog was canceled by user at 10:27 PM when medication was administered." Review of Resident #12's nursing notes dated April and May 2017 failed to reveal pain assessments prior to the administration of the above medications. On 5/25/17 at 10:35 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the nurse who administered Hydrocodone-Acetaminophen on 3/21/17 and 3/22/17. When asked about the process followed prior to administering prn (as needed) pain medications, LPN #4 stated that she would assess for the level of pain, try non-pharmacological interventions first and then administer pain medications. LPN #4 stated that she would reassess pain after the medication was administered. When asked if the assessed pain level should be documented, LPN #4 stated that the resident's pain level should be documented in the clinical record. LPN #4 stated that the EMAR (electronic medication administration record) pops up with a dialog box asking for the pain level when a pain medication is signed off on the MAR. When asked if she could recall assessing Resident #12's pain prior to administering prn Hydrocodone-Acetaminophen, LPN #12 stated, "Yes. I sometimes cancel the box and then forget to go to back and enter it in."	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

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F 514	Continued From page 97 On 5/25/17 at 11:06 a.m., an interview was conducted with Resident #12. Resident #12 stated that staff assesses her pain before giving medication. On 5/25/17 at approximately 12:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Regional QA (quality assurance) manager were made aware of the above findings. [1] Hydrocodone-Acetaminophen- indicated for the use of moderate to severe pain. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a909231f-b89d-401e-9b02-e5be28414459. 3 a. The facility staff failed to document Resident #5's transfer to the hospital from an endocrinology appointment on 5/16/17. Resident #5 was admitted to the facility on 5/15/17 and readmitted on 5/2217 with diagnoses that included but were not limited to shingles, neuropathy, dry eyes, hypothyroidism, diabetes, UTI (urinary tract infection), Gastrointestinal hemorrhage, and encephalopathy. Resident #5 had not yet had an MDS (minimum data set) assessment completed at the time of the survey. Resident #5's admission note dated 5/22/17, documented Resident #5 as being alert and oriented x 2 (To person and place). Resident #5 was documented	F 514		

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	495394		05/25/2017

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F 514	Continued From page 98 in the admission note dated 5/22/17, as requiring one person assist with toileting, ambulation, and eating. Review of Resident #5's clinical record revealed the following admission note dated 5/15/17: " Guest: (Name) admitted to room (room number) at 6:00 p.m., via stretcher and accompanied by son. VS (vital signs) on admission are as follows, T (temperature) 98.8, P (pulse) 88, R (respirations) 20, B/P (blood pressure) 161/79. Mental Status alert with confusion. Primary Dx (diagnoses) Shingles. Orders received and verified from hosp. (hospital). Guest is not able to be oriented to room, call bell and facility by staff. Guest requires extensive assist with ambulation, Requires extensive assist with toileting, Requires (sic) set up assist with eating. Guest can make needs known. Guest has no skin issues noted, and no catheter in place at this time...(Name of Doctor) informed of admission and will direct care during stay. Family notified of admission." Further review of Resident #5's clinical record revealed a second admission note dated 5/22/17. The following was documented: " 5-22-17 10:22 p.m., Guest (Name) admitted to room (room number) at 4:00 p.m. via stretcher and accompanied by SON. VS on admission are as follows, T 97.8, P 58, R 18, B/P 171/97. Mental Status A&O x 2 (alert and oriented to person and place). Guest WAS able to be oriented to room, call bell and facility by STAFF. Guest requires X 1 (one) assist with ambulation, Requires X 1 assist with toileting, Requires X 1 assist with eating. Guest CAN make needs known. Guest has NO skin issues noted besides some bruising and NO catheter in place at this time...(Name of doctor)	F 514		

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	495394		05/25/2017

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F 514	Continued From page 99 informed of admission and will direct care during guest stay." Nursing notes could not be found in the clinical record documenting that Resident #5 was transferred to the hospital or discharged prior to her 5/22/17 admission. On 5/25/17 at 10:29 a.m., an interview was conducted with RN (registered nurse) #4, the unit manager for the third nursing station. RN #4 stated that Resident #5 was sent out to an appointment on 5/16/17 and she was then admitted to the hospital from the appointment. RN #4 stated that she was made aware that the resident had not come back from the appointment later that day. RN #4 could not recall the appointment Resident #5 went to. When asked why Resident #4 was admitted to the hospital, RN #4 stated, "I really don't know. I can ask." When asked if it should be documented that Resident #5 went to an appointment and was admitted to the hospital from the appointment and the reason for admission, RN #4 stated, "Yes, it should be documented so we know where people are." When asked how nurses coming on shift would know what happened to Resident #5, RN #4 stated, "In verbal report." Review of the appointment book at the unit three nursing station documented the following for May 16 th, 2017: "(Name of Resident #5) VA (Virginia) Endocrinology at 11:45 (Name of physician) p/u (pick up) at 11:00 a.m." Nursing notes could not be found in the clinical record documenting that Resident #5 went to this appointment. Documentation could not be found	F 514		

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	495394		05/25/2017

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F 514	Continued From page 100 that Resident #5 was transferred to the hospital from this appointment. On 5/25/17 at approximately 12:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Regional QA (quality assurance) manager were made aware of the above findings. 3 b. The facility staff failed to document non-pharmacological interventions attempted prior to the administration of Tramadol [1] to Resident #5. Review of Resident #5's most recent POS (physician order sheet) dated 5/23/17 documented the following orders: "Tramadol HCL 50 mg (milligrams) tablet- one tab oral every 6 hour prn (as needed) pain." This order was initiated on 5/23/17. "Tylenol [2] 325 mg Caplet- Two TAB oral as needed every four hours pain." This order was initiated on 5/23/17. Review of Resident #5's May 2017 MAR (Medication Administration record) revealed the following orders: "Tramadol HCL 50 mg (milligrams) tablet- one tab oral every 6 hour prn; oral for pain. Tylenol 325 mg Caplet- Two TAB (tablet) oral as needed every four hours, oral for pain. Tylenol 325 mg Caplet- two tab every six hours prn, oral for pain. DC (discontinue): 5-23-17."	F 514		

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	495394		05/25/2017

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F 514	Continued From page 101 Further review of the May 2017 MAR revealed that Resident #5 received Tylenol 325 mg every six hours on 5/23/17 at 7:37 a.m. and Tramadol 50 mg on 5/23/17 at 11:55 a.m. The following was documented by the nurse on shift: "5/23/17 at 7:37 a.m. by (name of nurse): Auto created note: Unable to Determine Pain Level at 07:37 am when medication was administered; 0. Did not attempt non-medication intervention for pain; Pain/location/Complaint: generalized. 5/23/17 at 11:55 a.m. by (name of nurse): Auto created note: Unable to determine Pain Level at 11:55 am when medication was administered; Did not attempt non-medication intervention for pain; Location/Complaint: generalized." On 5/25/17 at 10:00 a.m., an interview was conducted with LPN (Licensed practical nurse) #7, Resident #5's nurse. When asked about the process followed prior to administering a prn (as needed) pain medication, LPN #7 stated that she would assess the resident's pain using a scale from 1-10. LPN #7 stated that she would also attempt non-pharmacological (interventions) prior to administering pain medications such as ice, heat and repositioning. When asked if she attempts non-pharmacological (interventions) for every resident, LPN #7 stated, "I won't always attempt. Some residents request pain medication before therapy." When asked if she attempted non-pharmacological interventions prior to administering Tylenol to Resident #5 on 5/23/17, LPN #7 stated, "I remember that. She was screaming out in pain but could not say what her pain level was. I administered the Tylenol and then repositioned her with therapy. That was not effective so I administered Tramadol." When asked if non-pharmacological interventions	F 514		

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	495394		05/25/2017

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F 514	Continued From page 102 attempted or offered are documented in the clinical record, LPN #7 stated that non-pharmacologicals (interventions) attempted should be documented on the MAR. LPN #7 stated that she must have forgotten to document the repositioning prior to giving the Tramadol. On 5/25/17 at approximately 12:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the Regional QA (quality assurance) manager were made aware of the above concerns. No further information was presented prior to exit. [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. [2] Tylenol Tablet 325 mg (Acetaminophen)- Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details. 4. The facility staff failed to document treatments on the May 2017 MAR (medication administration record) and TAR (treatment administration record) for Resident #4. Resident #4 was admitted to the facility on 1/16/17 and was readmitted on 3/20/17 with diagnoses that included but were not limited to: Parkinson's disease (1), urinary tract infection,	F 514		

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	495394		05/25/2017

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F 514	Continued From page 103 and low blood pressures upon standing. The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 4/3/17 coded Resident #4 as having scored a five out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could do after staff set up the meal tray. Review of Resident #4's physician's orders dated 5/18/17 documented in part the following: "ASSIST BAR when in bed for up as an enabler; SAFETY CHAIR: DYCEM BELOW CUSHION TO CHAIR/WHEELCHAIR check placement; every shift; TED STOCKINGS (2): BELOW THE KNEE bi-lateral (sic) legs; apply in am (morning); remove hs (bedtime); TREATMENT every shift Start: 03-21-17 Extended Directions: skin prep bilateral heels q (every) shift; TREATMENT every shift and as needed. Extended Directions: apply protective cream to sacrum qshift (every shift) and prn (as needed) for protection; WANDER BRACELET TO GUEST: CHECK PLACEMENT every shift; COSOPT PF (3) EYE DROPS one drop(s) twice daily; both eyes for glaucoma Start: 03-21-17; LATANOPROST 0.005% (4) EYE DROPS one drop(s) at bedtime; both eyes for glaucoma; METOPROLOL TARTRATE 25 MG (milligrams) (5) tab (tablet) for hypertension; SINEMET 25-100 MG (6) one tab three times daily; oral for parkinson's." Review of the May 2017 TAR documented the following: - "ASSIST BAR when in bed for up as an	F 514		

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	495394		05/25/2017

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F 514	Continued From page 104 enabler." Further review of the TAR did not evidence documentation that the treatment had been completed for eight out of 69 opportunities in the month of May 2017; there were eight blank spaces where nurses documented treatment was completed on the TAR. -"SAFETY CHAIR: DYCEM BELOW CUSHION TO CHAIR/WHEELCHAIR check placement; every shift." Review of the TAR did not evidence documentation that the treatment had been completed for seven out of 69 opportunities in the month of May 2017; there were seven blank spaces where nurses documented treatment was completed on the TAR. - "TED STOCKINGS: BELOW THE KNEE bi-lateral (sic) legs; apply in am (morning); remove hs (bedtime)." Review of the TAR did not evidence documentation that the treatment had been completed for six out of 47 opportunities in the month of May 2017; there were six blank spaces where nurses documented treatment was completed on the TAR. - "TREATMENT every shift. Extended Directions: skin prep bilateral heels q (every) shift." Review of the TAR did not evidence that the treatment had been completed for eight out of 69 opportunities in the month of May 2017; there were eight blank spaces where nurses documented treatment was completed on the TAR. - "TREATMENT every shift and as needed. Extended Directions: apply protective cream to sacrum qshift and prn (as needed) for protection" Review of the TAR did not evidence documentation that the treatment had been	F 514		

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	495394		05/25/2017

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F 514	Continued From page 105 completed on seven out of 69 opportunities in the month of May 2017; there were seven blank spaces where nurses documented treatment was completed on the TAR. - "WANDER BRACELET TO GUEST: CHECK PLACEMENT every shift" Review of the TAR did not evidence documentation that the bracelet had been checked for seven out of 69 opportunities in the month of May 2017; there were seven blank spaces where nurses documented treatment was completed on the TAR. Review of the May 2017 MAR documented the following: - "COSOPT PF EYE DROPS one drop(s) twice daily; both eyes for glaucoma." Review of the MAR did not evidence that the eye drops had been administered on one of 47 opportunities in the month of May 2017. - "LATANOPROST LATANOPROST 0.005% EYE DROPS one drop(s) at bedtime; both eyes for glaucoma." Review of the MAR did not evidence that the eye drops had been administered on three out of 23 opportunities in the month of May 2017. - "METOPROLOL TARTRATE 25 MG (milligrams) tab (tablet) for hypertension." Review of the MAR did not evidence that the medication had been administered on three out of 47 opportunities in the month of May 2017. - "SINEMET 25-100 MG one tab three times daily; oral for parkinson's." Review of the MAR did not evidence that the medication had been administered on two out of 70 opportunities in the month of May 2017. Review of the May 2017 nurse's notes did not	F 514		

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	495394		05/25/2017

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F 514	Continued From page 106 evidence documentation regarding the treatments or the medications. An interview was conducted on 5/24/17 at 1:10 p.m. with LPN (licensed staff nurse) #1, Resident #4's nurse, who had not documented a dose of Sinemet on 5/21/17 at 1:00 p.m. When asked what the blank space on the May 2017 MAR and TAR meant, LPN #1 stated, "It either wasn't given or it wasn't signed off." When asked why staff would not document on the MAR and TAR, LPN #1 stated, "We have an hour window to chart then it blanks out. You can go back in and chart what time you gave it." When asked about the Sinemet, LPN #1 stated she must have missed documenting the medication but was sure she had administered the drug. An interview was conducted on 5/24/17 at 1:20 p.m. with RN (registered nurse) #1, the unit manager. RN #1 was asked to review the May 2017 MAR and TAR for Resident #4. When asked what the blank spaces meant, RN #1 stated, "It apparently means that they did not initial. They should have initialed all of it. Meaning they've given the medication or they've done the treatment." When asked why staff documented, RN #1 stated so that other staff knew it was done. An interview was conducted on 5/24/17 at 3:32 p.m. with LPN #4, the resident's nurse who did not document treatments on several occasions. When asked to review the May 2017 TAR, LPN #4 stated, "Yes I did it. I didn't sign it out. The computer, it doesn't save it and you don't realize it (and know) to go back and put it back in." An interview was conducted on 5/24/17 at 3:45 p.m. with LPN #5, Resident #4's nurse who did	F 514		

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	495394		05/25/2017

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F 514	Continued From page 107 not document treatments and eye drops on at least one day. When asked to review the 2017 MAR and TAR, LPN #5 stated, "Sometimes on those computers it doesn't keep it (the documentation). Sometimes I have to enter it twice. I did it and then the computer has its issues." An interview was conducted on 5/24/17 p.m. with LPN #3, the resident's nurse who did not document some treatments and medications. When asked where treatments were documented, LPN #3 stated, "It's usually documented in the TAR." LPN #3 was asked what a blank box on the treatment record meant. LPN #3 stated, "If a block (on the TAR) is blank than it (the treatment) wasn't documented. There's been a couple time the computer didn't save it. But I did do it (the treatments)." On 5/24/17 at 5:40 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional QA manager were made aware of the findings. No further information was provided prior to exit. (1) Parkinson's disease -- Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html (2) TED stockings -- TED stockings (compression stockings) to help prevent blood clots, a possible complication of surgery. This information was	F 514		

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F 514	Continued From page 108 obtained from: https://www.cc.nih.gov/ccc/patient_education/postop/prepinpatientsurg.pdf (3) Cosoft PF -- COSOPT® PF is indicated for the reduction of elevated intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension who are insufficiently responsive to beta-blockers (failed to achieve target IOP determined after multiple measurements over time) This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a8d4e2b5-c7bb-48fc-9314-7095cd77617e (4) Latanoprost -- Latanoprost ophthalmic solution is indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f44d3f09-fa2d-4f01-831d-71a15bde5e29 (5) Metoprolol Tartrate -- Metoprolol tartrate and hydrochlorothiazide tablets are indicated for the management of hypertension. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=5571dc11-1c5c-41c1-be20-ed91b7ba5cc8 (6) Sinemet -- Carbidopa and levodopa extended release tablets are indicated in the treatment of the symptoms of idiopathic Parkinson's disease (paralysis agitans), postencephalitic parkinsonism, and symptomatic parkinsonism which may follow injury to the nervous system by	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495394		05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 109 carbon monoxide intoxication and/or manganese intoxication. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=abff005f-23fc-4d1e-b469-88aa07589a43	F 514		