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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/04/2017 through 04/06/2017. 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 142 certified bed facility was 116 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and 3 closed record reviews (Residents #22 through #24).	F 000	Disclaimer: This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions.	F 272	1. CAA's for resident #10 were reviewed and identified concerns were addressed by identifying the location of the documentation in the EMR. 2. Residents that have a comprehensive assessment have the potential to be affected. 3. Administrator/Designee to complete an audit of comprehensive assessments for a period of one month to ensure proper completion of CAA documentation. Re-Education provided by the Vice President of Clinical Reimbursement on 4/27/2017 regarding the completion of CAA's and appropriate use of dashes. MDS Coordinator will review CAA information from IDCP team and address any incomplete documentation with noted staff member at time of discovery. If improvements are not noted, it is expected that the department head be made aware to address further with staff. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	4/28/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dana Hazlewood, LNHA, MS	Administrator	5/1/2017

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

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F 272	Continued From page 1 (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate comprehensive MDS (minimum data set) for 1 of 24 Residents, Resident #10. The findings included: For Resident #10 the facility staff failed to accurately name the date and location of CAA (care area assessment) documentation. Resident #10 was admitted to the facility on 04/04/16 and readmitted on 10/20/16. Diagnoses included but not limited to anemia, hypertension,	F 272		

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F 272	Continued From page 2 hyperlipidemia, Alzheimer's disease, dementia, glaucoma, and dysphagia. The most recent MDS with an ARD (assessment reference date) of 04/11/16 coded the Resident as 1/1/3 in section C, cognitive patterns. This is equivalent to both short and long term memory loss and severely impaired cognitive skills. Section V, care area assessment, was reviewed. The facility staff had not identified the date and location of the CAA information used to determine the psychosocial care plan. The only documentation was "see CAA worksheet". The CAA worksheet was reviewed and the information could not be located. The surveyor spoke with the MDS coordinator on 04/04/17 at approximately 1430 regarding the missing CAA documentation. The MDS coordinator stated that she had not completed this MDS, but the previous MDS coordinator had. This MDS coordinator was no longer employed by the facility. The concern of the missing CAA documentation was discussed with the administrative staff during a meeting on 04/04/17 at approximately1545. No further information was provided prior to exit.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate	F 278	1. An MDS modification was completed on Resident #3's MDS Assessment ARD 7/1/2016 on 4/5/2017 to reflect resident's hip fracture. Resident #8 & #12's assessment reviewed and and identified concerns were addressed. The MDS Coordinator that completed assessment is no longer employed by the company. 2. Residents that have an assessment completed have the potential to be affected by this deficient practice.	4/28/2017

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F 278	Continued From page 3 participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for 3 of 24 Residents in the sample survey, Resident #3, Resident #12 and Resident #8. The Findings included: 1. For Resident #3 the facility staff failed to	F 278	3. Re-Education provided by the Vice President of Clinical Reimbursement on 4/27/2017 regarding the completion of CAA's and the proper use of dashes. An audit of comprehensive assessments submitted for the last month to be completed by Administrator/ Designee. MDS Coordinator will notify Administrator of any incomplete data or improperly used dashes with reason assessment cannot be completed with the reference date. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	

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complete Section F. Preferences for Customary Routine and Activities, and failed to code/capture a hip fracture on a Significant Change MDS and 5 Day Medicare assessment with an Assessment Reference Date (ARD) of 7/1/16.

Resident #3 was a 73 year old female who was originally admitted on 5/8/17 and readmitted on 2/5/17. Admitting diagnoses included, but were not limited to: glaucoma, cataracts, dysphagia, ocular hypertension bilaterally, chronic obstructive pulmonary disease, hypertension, osteoporosis and diabetes mellitus.

The most current MDS located in the clinical record was a Quarterly MDS with an ARD of 3/2/1. The facility staff coded that Resident #3 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #3 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's).

On April 5, 2017 at 9:15 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced Nursing Progress Notes dated 6/2/16 at 10:39 a.m. The Nursing Progress note read ... "Situation: CNA noted that rsd (resident) was in her room in the floor. Rsd fell in room while ambulating to her bathroom. V/S (vital signs) 142/74-72-9.3. Background: Rsd ambulates independently and is continent of B&B (bladder and bowel). Alert and oriented. Assessment: Rsd was laying on her left side on the floor when I entered the room. Upon assessment I noted rsd left leg was lying with the knee facing outward. Rsd said her whole left side hit the floor including her head. Tried making rsd comfortable but she yelled out in pain. Response: Contacted DNS (Director of Nursing Services),

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MD (physician) aware. RP (responsible party) called no answer left msg (message) to return call. Rsd sent to ER (emergency room) for further evaluation. Transported via stretcher (name of ambulance services withheld)." (sic)

Further review of the clinical record produced a Nursing Progress note dated 6/2/16 at 2:15 p.m. The Nursing Progress Note read... "resident has been admitted to (name of hospital withheld) for a left hip fracture due to fall." (sic)

Continued review of the clinical record produced physician progress notes dated 6/24/16, 6/30/16, 7/11/16 and 7/19/16 that documented Resident #3 was recently in the hospital with a left hip fracture and required an Open Reduction and Internal Fixation (ORIF) of the left hip.

Further review of the clinical record produced a Significant Change and 5 Day Medicare MDS assessment with an AD of 7/1/16. The surveyor reviewed the MDS. The surveyor noted that Section F. Preferences for Customary Routine and Activities was not completed. Every field in Section F was filled with dashes (--) that indicated that associated assessment was not completed. The facility staff coded that Resident #3 had a Cognitive Summary Score of 0. The facility staff also coded that Resident #3 required extensive (3/3) to total nursing care (4/2) with ADL's. In Section I. Active Diagnoses 13900.Hip Fracture was not coded/captured.

On April 5, 2017 at 11 a.m. the surveyor spoke with the MDS Nurse. The surveyor notified the MDS Nurse that Resident #3's Significant Change and 5 Day Medicare MDS was not accurate. The surveyor reviewed Resident #3's clinical record

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with the MDS Nurse. The surveyor specifically pointed out Resident #3's fall on 6/2/16 and admission into the hospital with a left hip fracture requiring an ORIF. The surveyor then reviewed the Significant Change and 5 Day Medicare MDS assessment with the MDS Nurse. The surveyor specifically pointed out that Section F was not completed and filled with dashes (--) throughout the assessment. The surveyor then reviewed Section I Active Diagnosis with the MDS Nurse. The surveyor pointed out that the MDS was not coded accurately to capture Resident #3's recent hip fracture.

On April 5, 2017 at 3:45 p.m. the survey team met with the Administrator (Adm) and the Interim Director of Nursing (IDON). The surveyor informed the Administrative Team (AT) that Resident #3's Significant Change and 5 Day Medicare MDS assessment was inaccurate. The surveyor notified the AT that Section F was not completed and that Section I did not capture/code Resident #3's recent hip fracture.

No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS for Resident #3.

2. The facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) for Resident #12.

Resident #12 was admitted to the facility on 6/8/11 with diagnoses of dementia, anemia, hypertension, psychosis, metabolic encephalopathy, insomnia, depression, and pneumonia.

The quarterly MDS with a reference date of

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1/23/17 assessed the resident with a cognitive score of "12" of "15". The resident was assessed requiring extensive assistance for bed mobility, dressing, transfers, toileting, hygiene and bathing.

The annual MDs with a reference date of 11/24/16 was reviewed. The facility staff failed to complete the Section "C" for Cognitive Patterns. The staff only wrote a "-" (dash) in each area of assessment. The next incomplete section was Section "J" for Health Conditions. The area for pain assessment was marked as "not assessed" for Pain Assessment Interview and also for Staff Assessment of Pain.

The MDS coordinator was interviewed on 4/5/17 at 2:15 p.m. The MDS coordinator stated the sections should have been completed and the person performing the assessment was no longer an employee of the facility.

The administrator and acting director of nursing were informed of the finding during the end of the day meeting with the survey team on 4/5/17 at 4:00 p.m. The administrator stated she had terminated the employee for not completing the assessments.

3. For Resident #8 the facility staff failed to complete section C and section J of the MDS (minimum data set).

Resident #8 was admitted to the facility on 10/11/16 and readmitted on 11/126/16. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, hyponatremia, anxiety, bipolar disorder, schizophrenia, chronic obstructive pulmonary disease, hypothyroidism, atrial fibrillation, gastroesophageal reflux disease, and irritable bowel syndrome.

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The most recent MDS with an ARD (assessment reference date) of 01/10/17 coded the Resident as 15 out of 15 in section C, cognitive patterns. The most recent comprehensive MDS with an ARD of 10/17/16 was reviewed. Section C. cognitive patterns and section J, pain assessment interview had not been completed. The items in these sections were marked with a dash.

The surveyor spoke with the MDS coordinator on 04/04/17 at approximately 1430 regarding the inaccurate MDS. The MDS coordinator stated that she had not completed this MDS, but the previous MDS coordinator had. This MDS coordinator was no longer employed by the facility.

The concern of the inaccurate MDS was discussed with the administrative staff during a meeting on 04/04/17 at approximately1545.

No further information was provided prior to exit.

F 323 SS=D 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

(d) Accidents.
The facility must ensure that -

(1) The resident environment remains as free from accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or

F 323 1. Biohazard room door lock changed to an automatic lock immediately during inspection on 4/5/2017. 4/28/2017

2. South Wing is the only area of the building that houses the biohazard wastes. Area secured prior to inspectors leaving the building and continues to have a lock in place to secure the area.

3. Maintenance Department/Designee to audit/check Biohazard Door weekly to ensure door is secure, locked, and free of any potential hazard to residents in accordance with F323. Any issues noted with lock are to be reported to maintenance.

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F 323	Continued From page 9	F 323	4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	

bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility staff failed to ensure a safe and hazard free environment for 1 of 3 wings in the facility, South wing.

The findings included:

For South wing, the facility staff failed to keep the door to the biohazard storage area locked.

On 04/04/17 at approximately 1535, during general observations of the facility, the surveyor checked the door to the biohazard storage area and found it to be unlocked. The room contained large trash cans with full trash bags in them, sharps containers, and broken down cardboard boxes. The surveyor checked the door to the biohazard storage area again on 04/05/17 at approximately 0930, and found it to still be unlocked. The surveyor asked a facility staff person, who identified herself as medical records personnel, what was kept in the room and she stated "Used sharps boxes, anything

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contaminated with blood, urine or feces." Surveyor then asked if the room should be kept locked, and staff member stated "yes, it should, I'll lock it now". Surveyor checked the biohazard storage area again on 04/05/17 at approximately 1420, it was again unlocked. Housekeeping staff was outside the door when surveyor checked it and stated "I thought I locked that".

The concern of the biohazard storage area door being unlocked was discussed with the administrative team during a meeting on 04/05/17 at approximately 1545. The administrator stated that she had told staff to make sure the door remained locked at all times.

Surveyor checked the biohazard storage area door on 04/06/17 at approximately 0930 and found it be locked.

During a meeting with the administrative staff on 04/06/17 at approximately 1040, the administrator informed the survey team that she had maintenence replace the lock on the biohazard storage door with an automatic lock.

No further information was provided prior to exit.

F 328 SS=D 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS

(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

F 328 1. An assessment was completed by a Licensed Nurse and the physician was notified of the findings for Resident #3. Physician continued order for oxygen PRN for Resident #3. Assessment and physician follow-up were completed on 4/4/2017. Nebulizer mask and tubing for Resident #3 placed in storage bag during inspection on 4/4/2017. 4/28/2017

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(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.

(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.

F 328 2. All residents receiving oxygen have the potential to be affected by this deficient practice.
3. Audit completed by DNS/Designee of residents receiving oxygen. All residents with orders for nebulizer treatments had a room inspection 4/4/2017 to ensure bags in use in compliance with F328. Re-education completed with all nursing staff regarding orders for oxygen as well as oxygen and nebulizer tubing to be in bags at all times when not in use. Audits to be completed weekly x4 weeks and then monthly x 3 to ensure compliance with F328.
4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.

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(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, staff interview and clinical record review it was determined that the facility staff failed to obtain a physician order prior to providing oxygen, and failed to store oxygen equipment in a clean and sanitary manner for 1 of 24 Residents in the sample survey, Resident #13.

The Findings Included:

Resident #13 was a 65 year old female who was admitted on 5/19/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, chronic kidney failure, non-rheumatic mitral insufficiency, congestive heart failure, morbid obesity, diabetes mellitus, hypertension and Schizophrenia.

The most current Minimum Data Set located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 2/3/17. The facility staff coded that Resident #13 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #13 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's).

On April 4, 2017 at 3 p.m. the surveyor observed Resident #13 lying in bed. Resident #13 was receiving oxygen via a nasal cannula at 3 liters per minute. The surveyor also observed a

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nebulizer mask that was lying out and open for use on the bedside table. The nebulizer was not stored in a sanitary manner.

On April 4, 2017 at 3:05 p.m. the surveyor reviewed Resident #13's clinical record. Review of the clinical record produced signed physician orders dated 3/1/17. Signed physician orders did not include a physicians' order for Resident #13 to receive oxygen. Continued review of the clinical record produced a physician order dated 2/28/17. The physicians' order ordered Albuterol Sulfate Nebulization Solution four times a day.

On April 4, 2017 at 3:30 p.m. the surveyor notified the Interim Director of Nursing (IDON) that Resident #13's was receiving oxygen and that review of the clinical record did not produce a physicians' order to receive/administer oxygen. The surveyor also notified the IDON that Resident #13's nebulizer equipment was lying on the bedside table and not stored in a sanitary manner. The surveyor and IDON reviewed Resident #13's clinical record. The IDON could not locate a physician order for Resident #13 to receive oxygen. The surveyor asked how the nebulizer equipment was supposed to be stored. The IDON stated she had already asked the nurse to go place the nebulizer equipment in a storage bag.

On April 5, 2017 at 3:45 p.m. the survey team met with the Administrator (Adm) and the IDON. The surveyor informed the Administrative Team (AT) that the Resident #13 was receiving oxygen and a physicians' order for oxygen could not be located in the clinical record. The surveyor also notified the AT that Resident #13's nebulizer equipment was not stored in a clean and sanitary manner.

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F 328	Continued From page 14 No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to obtain a physician order prior to administering oxygen and why the facility staff failed to store nebulizer equipment in a clean and sanitary manner for Resident #13.	F 328		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 (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	F 329	1. Resident #13's order for Losartin was reviewed and MD notified. Per MD order, supplementary documentation was put in place which prompts the licensed nurse to document BP prior to signing off the medication. 2. All residents receiving BP medication have the potential to be affected by the deficient practice. 3. Audit of residents receiving BP medication completed by DNS/Designee. Any residents that had orders for parameters had supplementary documentation added to prompt licensed nursing to document BP as needed. Any residents with new orders for BP medications will be reviewed as well. Audits to continue weekly x 4 weeks, then monthly x 3 to ensure compliance with F329. Licensed Nursing Staff re-educated regarding BP orders and placing parameters in supplementary documentation. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	4/28/2017

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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 and clinical record review it was determined that the facility staff failed to follow physician ordered medication parameters for 1 of 24 Residents in the sample survey, Resident #13.

The Findings Included:

Resident #13 was a 65 year old female who was admitted on 5/19/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, chronic kidney failure, non-rheumatic mitral insufficiency, congestive heart failure, morbid obesity, diabetes mellitus, hypertension and Schizophrenia.

The most current Minimum Data Set located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 2/3/17. The facility staff coded that Resident #13 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #13 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's).

On April 4, 2017 at 3:05 p.m. the surveyor reviewed Resident #13's clinical record. Review of the clinical record produced signed physician

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orders dated 3/1/17. Signed physician orders included, but were not limited to: "Losartan Potassium Tablet 100 MG Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) **HOLD IF SYSTOLIC BP (blood pressure) IS< (less than) 120**" (sic

Continued review of the clinical record produced the March and April 2017 Medication Administration Records (MAR's). The MAR's documented that the facility staff administered the Losartan as ordered by the physician. Continued review of the MAR's failed to document that the blood pressure was obtained and that physician ordered blood pressure parameters were being followed as ordered by the physician.

Further review of the clinical record failed to document that the blood pressure was obtained daily with the administration of the Losartan.

On April 5, 2017 at 8:40 a.m. the surveyor notified the Interim Director of Nursing (IDON) that Resident #13 had a physician order to receive Losartan daily and had physician ordered blood pressure parameters. The surveyor notified the IDON that the facility staff was supposed to hold the medication if the systolic blood pressure was less than 120. The surveyor notified the IDON that she could not locate blood pressures associated with the medication administration. The surveyor and IDON reviewed Resident #13's clinical record. The surveyor specifically pointed out the physician order for the Losartan and blood pressure parameters. The IDON reviewed the clinical record and was unable to locate blood pressures associated with the medication

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F 329	Continued From page 17 administration. On April 5, 2017 at 3:45 p.m. the survey team met with the Administrator (Adm) and the IDON. The surveyor informed the Administrative Team (AT) that the Resident #13 had physician ordered blood pressure parameters associated with the administration of the Losartan. The surveyor notified the AT that review of the clinical record failed to produce blood pressures associated with the Losartan medication administration. No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to follow physician ordered medication/blood pressure parameters for Resident #13.	F 329		
F 502 SS=D	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered laboratory (lab) testing for 2 of 24 residents (Resident #7 and #10). The findings include: 1. The facility staff failed to obtain a physician ordered lab test for a Vitamin D level for Resident #7.	F 502	1. Resident #7's Physician and Responsible Party notified of lab omission on 4/5/2017. Lab discontinued. Resident #10's Physician and Responsible party notified of lab omission on 4/5/2017. No New Orders at this time. 2. All residents have the potential to be affected by this deficient practice. 3. Audit of all lab orders from the last month completed by DNS/Designee. Lab audits to be completed daily x 4 weeks then weekly x 3 months to ensure compliance with F 502. Re-education completed with all Licensed Nursing staff in regards to lab omissions and notifying MD when a lab is not obtained. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.	4/28/2017

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Resident #7 was admitted to the facility on 7/14/16 with diagnoses of dementia with behaviors, dysphagia, hypertension, kidney failure, anxiety, psychosis, ileus, stroke, subarachnoid hemorrhage, and follicular lymphoma.

The significant change Minimum Data Set with a reference date of 12/5/16 assessed the resident with short and long term memory deficit and requiring extensive assistance for decision making. The resident was assessed requiring extensive assistance of 2 persons fro bed mobility, transfers, dressing, toileting, bathing, and hygiene.

The clinical record was reviewed. The physician had written a telephone order dated 1/22/17 for lab testing for a "CBC- CMP-TSH- Vit D-B12-Folic Acid" .

The clinical record was reviewed for the lab results and no Vitamin D level was found. The facility supervisor (RN#3) was asked on 4/5/17 at 8:30 a.m. about the missing lab test. RN#3 reviewed the record and stated the Vitamin D level was not obtained as ordered.

The administrator and acting director of nursing were informed of the finding during the end of the day meeting with the survey team on 4/5/17 at 4:00 p.m.
2. For Resident #10 the facility staff failed to obtain the physician ordered CMP (comprehensive metabolic panel).

Resident #10 was admitted to the facility on 04/04/16 and readmitted on 10/20/16. Diagnoses included but not limited to anemia, hypertension,

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hyperlipidemia, Alzheimer's disease, dementia, glaucoma, and dysphagia.

The most recent MDS with an ARD (assessment reference date) of 04/11/16 coded the Resident as 1/1/3 in section C, cognitive patterns. This is equivalent to both short and long term memory loss and severely impaired cognitive skills.

Resident #10's clinical record was reviewed on 04/05/17. It contained a signed physician's order dated 10/31/16 which read in part "N.O. (new order) repeat CBC (complete bloc count) and CMP in 1 week 11/07/16". The surveyor could not locate the results of the CMP in the Resident's clinical record. Surveyor asked the ADON (assistant director of nursing) if she could locate the missing lab results and she could not.

The concern of the missing lab results was discussed with the administrative team during a meeting on 04/05/17 at approximately 1545.

No further information was provided prior to exit.

F 504 SS=D 483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN

(a) Laboratory Services

(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:

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1. Resident #10's Physician and Responsible Party made aware that CMP was drawn on 10/31/2016 and a BMP was drawn on 10/24/2016. There were no new orders at this time.

2. Residents that have lab orders have the potential to be affected by this deficient practice.

3. All Licensed Nursing Staff re-educated on lab scheduling procedure and obtaining physician orders for labs. Lab orders from the last month were audited by DNS/Designee to ensure compliance with F504. Audits to continue daily x 4 weeks, then weekly x 3 months to ensure continued compliance with F504.

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Based on staff interview and clinical record review the facility staff failed to obtain a physician's order prior to obtaining a lab for 2 of 24 Residents, Resident #10 and Resident #7.

The findings included:

1. For Resident #10 the facility staff failed to obtain an order for CMP (complete metabolic panel) done on 10/31/16 and a BMP (basic metabolic panel) done on 10/24/16.

Resident #10 was admitted to the facility on 04/04/16 and readmitted on 10/20/16. Diagnoses included but not limited to anemia, hypertension, hyperlipidemia, Alzheimer's disease, dementia, glaucoma, and dysphagia.

The most recent MDS with an ARD (assessment reference date) of 04/11/16 coded the Resident as 1/1/3 in section C, cognitive patterns. This is equivalent to both short and long term memory loss and severely impaired cognitive skills.

Resident #10's clinical record was reviewed on 04/05/17. It contained a lab report dated 10/24/16 for a BMP. The surveyor could not locate a physician's order for this lab test. The clinical record also contained a lab report dated 10/31/16 for a CMP. The surveyor could not locate a physician's order for this lab test. Surveyor asked the ADON (assistant director of nursing) if she could locate the physician's orders for this lab test. The ADON provided the surveyor with a copy of a signed physician's order dated 10/20/16 which read in part "CBC weekly x 4 weeks to begin on Monday 10/24/16, 10/31/16, and 11/07/16. Surveyor informed ADON that this order was only for CBC and not the other lab tests.

F 504 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations implemented as indicated.

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The concern of the missing physician's orders was discussed during a meeting with the administrative staff on 04/05/17 at approximately 1545.

No further information was provided prior to exit.
2. The facility staff failed to obtain a physician order for a lab test for a Basic Metabolic Panel (BMP) level for Resident #7.

Resident #7 was admitted to the facility on 7/14/16 with diagnoses of dementia with behaviors, dysphagia, hypertension, kidney failure, anxiety, psychosis, ileus, stroke, subarachnoid hemorrhage, and follicular lymphoma.

The significant change Minimum Data Set with a reference date of 12/5/16 assessed the resident with short and long term memory deficit and requiring extensive assistance for decision making. The resident was assessed requiring extensive assistance of 2 persons fro bed mobility, transfers, dressing, toileting, bathing, and hygiene.

The clinical record was reviewed. The physician had written an order for a BMP dated for 3/7/17.

The clinical record was reviewed for the lab results and lab results for a BMP performed 3/1/17 were in the clinical record. The facility supervisor (RN#3) was asked on 4/5/17 at 8:30 a.m. about the order for the lab test. RN#3 reviewed the record and stated there was no physician order for that lab test.

The administrator and acting director of nursing

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were informed of the finding during the end of the day meeting with the survey team on 4/5/17 at 4:00 p.m.

F 514 SS=D 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

(i) Medical records.
(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(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

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F 514 1. Resident #3's order was removed from resident's chart and filed in correct medical record on 4/5/2017. Resident #13 had physician order sheet updated and re-signed on 4/4/2017 to reflect the addition of Ergocalciferol which was originally ordered on 2/6/2017. Resident #8's order for fluid restriction reviewed by resident's physician. Order per physician is now "Strict 2000 ml fluid restriction per 24 hour period". Resident #8's MAR's reviewed for compliance.
2. Residents have the potential to be affected by this deficient practice.
3. Audit of all medical records to be completed by Health Information Management department to ensure resident's information is not co-mingled in medical records. An audit audit also to be completed to ensure all resident's Physician's order sheets are signed at the first of every month. Missed Documentation Report to be utilized every day to ensure compliance with F514. All staff re-educated on filing correct documentation in charts. All Licensed Nursing Staff re-educated on Physician's Order Sheet's being signed by the first of the month. All Licensed Nursing Staff also educated on completely signing all documentation on the MAR.
4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.

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services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for 3 of 24 Residents in the sample survey, Resident #3, Resident #13 and Resident #8.

The Findings included:

1. For Resident #3 the facility staff failed to ensure a complete and clinical record. Another resident's physician order was commingled in Resident #3's clinical record.

Resident #3 was a 73 year old female who was originally admitted on 5/8/17 and readmitted on 2/5/17. Admitting diagnoses included, but were not limited to: glaucoma, cataracts, dysphagia, ocular hypertension bilaterally, chronic obstructive pulmonary disease, hypertension, osteoporosis and diabetes mellitus.

The most current MDS located in the clinical record was a Quarterly MDS with an ARD of 3/2/1. The facility staff coded that Resident #3 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #3 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's).

On April 5, 2017 at 9:15 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced a physician telephone order for another Resident in Resident #3's clinical record. The physician telephone order was dated 2/27/17 and read ... "HydrALAZINE HCl Tablet 25 MG Give 25 mg by

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mouth one time only related to UNSPECIFIED COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGESTIVE) HEART FAILURE (i50.40) until 2/27/17 23:59 give 25 mg po (by mouth) now for elevated b/p (blood pressure) and recheck b/p in 1 hr." (sic)

On April 5, 2017 at 9:55 a.m. the surveyor notified the Interim Director of Nursing (IDON) that another Resident's physician telephone order was contained in Resident #3's clinical record. The surveyor reviewed the clinical record with the IDON. The surveyor specifically pointed out the physician order dated 2/27/17 for Hydralazine.

On April 5, 2017 at 3:45 p.m. the survey team met with the Administrator (Adm) and the IDON. The surveyor informed the Administrative Team (AT) that another Resident's physician order was contained in Resident #3's clinical record. The surveyor notified the AT that Resident #3's clinical record was not complete and accurate.

No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #3.

2. For Resident #13 the facility staff failed to ensure complete and accurate Physician Order Sheets (POS's).

Resident #13 was a 65 year old female who was admitted on 5/19/16. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, chronic kidney failure, non-rheumatic mitral insufficiency, congestive heart failure, morbid obesity, diabetes mellitus, hypertension and Schizophrenia.

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	495143	A. BUILDING _____ B. WING _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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The most current Minimum Data Set located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 2/3/17. The facility staff coded that Resident #13 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #13 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's).

On April 4, 2017 at 3:05 p.m. the surveyor reviewed Resident #13's clinical record. Review of the clinical record produced signed physician orders dated 3/1/17.

Continued review of the clinical record produced a physician order dated 2/6/17. The physician order read in part ... "Ergocalciferol 50,000 units once a week X (times/for) 6 weeks." (sic)

The surveyor noted that the signed and dated, 3/1/17, physician orders did not include the order for the Ergocalciferol.

On April 4, 2017 at 3:30 p.m. the surveyor notified the Interim Director of Nursing (IDON) that Resident #13's Physician Order Sheets, dated 3/1/17, were inaccurate/incomplete. The surveyor reviewed the clinical record with the IDON. The surveyor specifically pointed out the physician order dated 2/6/17 that ordered the Ergocalciferol weekly for 6 weeks. The surveyor then reviewed the POS's dated 3/1/17. The surveyor pointed out that the POS's did not include the order for the Ergocalciferol. The surveyor notified the IDON that the order had not been transcribed to the POS's prior to the physician signing the orders on 3/1/1/7.

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On April 5, 2017 at 3:45 p.m. the survey team met with the Administrator (Adm) and the IDON. The surveyor informed the Administrative Team (AT) that the most current signed POS's did not include the physician order dated 2/6/17 for the Ergocalciferol. The surveyor notified the AT that Resident #13's POS's/clinical record were not complete and accurate.

No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #13.

3. For Resident #8 the facility staff failed to ensure a complete and accurate MAR (medication administration record).

Resident #8 was admitted to the facility on 10/11/16 and readmitted on 11/26/16. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, hyponatremia, anxiety, bipolar disorder, schizophrenia, chronic obstructive pulmonary disease, hypothyroidism, atrial fibrillation, gastroesophageal reflux disease, and irritable bowel syndrome.

The most recent MDS with an ARD (assessment reference date) of 01/10/17 coded the Resident as 15 out of 15 in section C, cognitive patterns. This is a quarterly MDS.

Resident #8's clinical record was reviewed on 04/05/17. It contained a signed physician's order summary which read in part "strict 2000ml fluid restriction per 24 hour period every shift to keep sodium level wnl (within normal limits) per md order". Resident #8's MAR's for the months of February, March and April 2017 were reviewed.

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F 514	Continued From page 27 The MAR's contained an entry which read in part "strict 2000ml fluid restriction per 24 hour period every shift to keep sodium level wnl (within normal limits) per md order". For the month of February 2016, the MAR had not been signed on 02/09 evening shift. For the month of March, the MAR had not been signed on 03/01and 03/24 day shift, and 03/15 and 03/23 on evening shift. The concern of the missing documentation was discussed with the administrative team during a meeting on 04/05/17 at approximately 1545. No further information was provided prior to exit.	F 514		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as	F 520	1. Medical Director notified immediately and educated that he must be in attendance quarterly for facility Quality Assurance Performance Improvement (QAPI) Meetings. Administrator reviewed F520 on 4/6/2017 and his duty to attend and be active with the committee. He is aware that his signature indicates attendance at this meeting. 2. No residents were affected by this deficient practice. 3. Medical Director re-educated immediately on F520. The Medical Director is aware of his role on the committee. A calendar has been provided to the Medical Director for the remaining dates for the monthly QAPI Meeting for the remainder of 2017 so that he may plan accordingly or send a designee in his absence. An audit will be conducted monthly by the Administrator/Designee to ensure compliance with F520. 4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting for review and recommendations implemented as indicated.	4/28/2017

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identifying issues with respect to which quality assessment and assurance activities are necessary; and

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;

(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, it was determined that the facility staff failed to ensure that the Medical Director (MD) or his Designee attended Quarterly Quality Assurance meetings.

The Findings Included:

On April 6, at 10:30 a.m. the surveyor met with the Administrator (Adm). The surveyor discussed the facility's Quality Assurance (QA) program and requested to see the QA meeting signatures sheets of the people who attended the QA meetings. The Adm produced the QA manual. The surveyor reviewed the manual and noted that the facility had conducted QA meetings monthly since the facility's last survey in April 2016. The surveyor reviewed the QA meeting signature sheets of the facility staff and Medical Director

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(MD) who attended the QA meetings. The surveyor noted that the facility had a QA meeting on 5/19/16, 6/15/16 and 7/20/16. The surveyor noted that the MD had not signed the signature sheet verifying his presence and attendance of the QA meeting. The surveyor reviewed the May, June and July 2016 QA signature sheets with the Adm. The surveyor pointed out that the MD had not signed the signature sheets and that the facility staff could not validate the MD attendance of the QA meetings. The surveyor notified the Adm that the MD had not attended the QA meetings quarterly

On April 6, 2017 at 10:40 a.m. the survey team met with the Adm and Interim Director of Nursing (IDON). The surveyor notified the Administrative Team (AT) that the MD had not attended QA meetings at least quarterly. The surveyor informed the AT that the MD had not signed the QA signature sheets for the May 19, 2016, June 15, 2016 and July 20, 2016.

No additional information was provided to the survey team prior to exiting the facility as to why the facility MD failed to attend quarterly QA meetings.

Survey Response Form

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

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

Sincerely,

Rodney L. Miller, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joann Atkins, Dmas (Sent Electronically)