STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW NURSING HOME	1776 ELLY ROAD ARODA, VA 22709

(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 1/20/16 through 1/21/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 40 certified bed facility was 40 at the time of the survey. The survey sample consisted of 9 current resident reviews (Residents #1 through #9) and one closed record review (Residents #10).	F 000	The submission of the Plan of Correction does not constitute agreement on the part of Mountain View Nursing Home that the deficiencies cited within the report represent deficient practices on the part of Mountain View Nursing Home. This plan represents our on-going pledge to provide quality care that is rendered in accordance with all regulatory requirements.	
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2-5-16

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

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F 157	Continued From page 1 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. 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 notify the physician of elevated blood sugars, per the physician orders, for one of ten residents in the survey sample, Resident #3. The facility staff failed to notify the physician, per the physician orders, when Resident #3's blood sugar was greater than 150 mg/dl (milligrams/deciliter) for three months. The findings include: Resident #3 was admitted to the facility on 1/14/13 with a readmission on 4/9/15 with diagnoses that included but were not limited to: dementia, schizophrenia, chronic kidney disease, psychosis, hyperlipidemia, high blood pressure, depression, diabetes and a hip fracture. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/16/15, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more	F 157	**Criterion 1. - F157** Resident #3 deceased on January 29, 2015 **Criterion 2.** 100% audit of all current residents with orders for blood sugar parameters and physician notification for the month of January. Any variances found during the audit, notifications will be made to the physicians and documented in the medical record. **Criterion 3.** Changes will be made to the computer system to allow greater visibility of the entire physician order, including parameters of physician orders. Licensed nursing staff will be educated on computer system changes and on the importance of reporting results outside of the parameters on physician orders for blood sugars. **Criterion 4.** DON or designee will audit the charts weekly for residents with orders for blood sugars with parameters for 6 weeks to ensure that physicians are notified for blood sugars outside of the parameters. Variances will be investigated, will be corrected as necessary, and responsible staff will be reeducated. Any variances identified will be tracked and trended and reported to the QAPI committee for any additional input. **Criterion 5.** March 1, 2016	

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F 157	Continued From page 2 staff members for all of her activities of daily living, except eating in which she required supervision after set up assistance was provided. The review of the physician orders dated, 11/3/15, and signed by the physician on 11/4/15 and then electronically signed on 1/6/16 by the physician, documented, "Fasting Blood Glucose (sugar) Monitoring, check via finger stick one time a day every Mon (Monday), Wed (Wednesday) and Fri (Friday) related to DIAB (diabetes) W/O (without) MENTION COMP (COMPLICATIONS); NOTIFY MD (Medical doctor) IF GREATER THAN 150 MG/DL (milligram/deciliter)." A review of Resident #3's MARs (medication administration records) for November and December 2015 and January 2016 was conducted. The following blood sugars were documented: November 2015: 11/4/15 - 162 11/6/15 - 159 11/9/15 - 167 11/11/15 - 164 11/13/15 - 187 11/16/15 - 164 11/18/15 - 177 11/20/15 - 173 11/23/15 - 171 11/25/15 - 176 11/27/15 - 162 11/30/15 - 172 December 2015: 12/2/15 - 185 12/4/15 - 169 12/7/15 - 178	F 157		

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F 157	Continued From page 3 12/9/15 - 168 12/11/15 - 176 12/14/15 - 181 12/16/15 - 187 12/18/15 - 170 12/21/15 - 184 12/28/15 - 198 12/30/15 - 201 January 2016: 1/1/16 - 181 1/4/16 - 205 1/6/16 - 214 1/8/16 - 198 1/11/16 - 187 1/13/16 - 199 1/15/16 - 269 1/18/16 - 195 1/20/16 - 179 Review of the nurse's notes from 11/1/15 through 1/20/16 did not reveal any documentation of notification to the physician for the blood sugars above 150 mg/dl as ordered. An interview was conducted with RN (registered nurse) #1 on 1/21/16 at 10:44 a.m. The above physician order was reviewed with RN #1. When asked what she would do with that order if the resident's blood sugar was greater than 150 mg/dl, RN #1 stated, "I'd call the doctor." When asked if she was to call the doctor each time the blood sugar was greater than 150, RN #1 stated, "Yes." When asked how she would communicate with the doctor, RN #1 stated, "We can fax them or email them." RN #1 was asked if the notification to the physician had to be documented and if so where. RN #1 stated, "Yes, it has to be documented in the progress notes."	F 157		

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F 157	Continued From page 4 An interview was conducted with the director of nursing (DON), ASM (administrative staff member) #2, on 1/21/16 at 10:47 a.m. The above physician order was reviewed with the DON. When asked what the nurse is expected to do with that order, the DON stated, "If the resident's blood sugar is greater than the 150 we have to notify the doctor." The facility policy, "Diabetic Care Regimen" documented, "Notify MD (medical doctor), if FSBS (finger stick blood sugar) > (Greater than) 400 with S/S (signs and symptoms) of hyperglycemia or if FSBS < (less than) 50 with S/S of hypoglycemia, unless otherwise noted." In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. The administrator, ASM #1 and DON, ASM #2 were made aware of these findings on 1/21/16 at 1:10 p.m. No further information was provided prior to exit.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	Continued From page 5 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to clarify physician orders for three of ten residents in the survey sample, Resident #2, Resident #4 and Resident #6. 1. The facility staff failed to clarify at what pain level the three different pain medications ordered should be administered for Resident #2. 2. The facility staff failed to clarify at what pain level the two different pain medications ordered should be administered for Resident #4. 3. The facility staff failed to clarify a physician order for notification of the physician for finger stick blood sugar levels for Resident #6. The findings include: 1. The facility staff failed to clarify at what pain level the three different pain medications ordered should be administered for Resident #2. Resident #2 was admitted to the facility on 9/17/14 with a readmission on 1/4/16 with diagnoses that included but were not limited to: urinary tract infection, dementia, chronic kidney disease, high blood pressure, arthritis and Alzheimer's disease. Resident #2's most recent MDS (minimum data	F 281	**Criterion 1. – F281** Resident #2 orders for pain management were clarified on Feb 5, 2016 Resident #4 orders for pain management were clarified on Feb 5, 2016 Resident #6 orders for blood sugar parameters were clarified on Feb 5, 2016 **Criterion 2.** Other residents with orders for multiple PRN pain medications and residents with orders for blood-sugar finger-sticks will be audited and reviewed for clarity. Any variance will be investigated and physician will be contacted for clarification. **Criterion 3.** Changes will be made to the computer system to allow greater visibility of the entire physician order, including parameters of physician orders. Licensed nursing staff will be educated on the importance of clarifying physician orders. **Criterion 4.** DON or designee will audit all charts weekly for residents with orders for blood sugars with parameters and multiple PRN pain medications for 6 weeks to ensure that physicians are notified for blood sugars outside of the parameters. Variances will be investigated, will be corrected as necessary, and responsible staff will be reeducated. Any variances identified will be tracked and trended and reported to the QAPI committee for any additional input. **Criterion 5.** March 1, 2016	

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F 281	Continued From page 6 set), a quarterly assessment, with an ARD (assessment reference date) of 12/23/15 coded the resident as being severely impaired cognitively to make daily decisions. In Section J -- Health conditions of the MDS the resident was coded as receiving pain medication regimen and that the resident received PRN (as needed) pain medications, had pain almost constantly and rated her pain as a ten out of ten. A review of the physician's orders dated 10/21/15 to 1/21/16 documented, "TRAMADOL HCL* (hydrochloride) 50 MG (milligrams) TABLET Give 1 tablet by mouth every 4 hours as needed for Pain. Hydrocodone-Acetaminophen** Tablet 5-325 MG Give 2 tablet by mouth as need for pain related to GENERALIZED PAIN. MAPAP*** 325 TABLET Give 2 tablet (sic) by mouth one time only for pain until 12/10/15 23:59 (11:59 p.m.) AND Give 2 tablet (sic) by mouth two times a day for Pain." There was no pain rating documented from the physician as to when each medication should be given. A review of Resident #2's care plan documented in part, "Focus, The resident has chronic pain r/t (related to) Osteoarthritis and aging process. Interventions, Give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness." A review of the 11/15 MAR (medication administration record) documented the resident received Hydrocodone-Acetaminophen 15 times for pain ratings ranging from a score of three to eight. The resident received Tramadol HCL eight times for pain ratings ranging from a score of five to eight. On five days at different times the resident received the	F 281		

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F 281	Continued From page 7 Hydrocodone-Acetaminophen and the Tramadol. A review of the 12/15 MAR documented that Resident #2 received MAPAP twice a day for pain. The resident received Hydrocodone-Acetaminophen 18 times for pain ratings ranging from a score of four to ten. Tramadol HCL 50 mg was given 19 times for pain ratings ranging from a score of four to ten. On eight days at different times the resident received the Hydrocodone-Acetaminophen and the Tramadol. A review of the 1/16 MAR documented the resident received MAPAP twice a day for pain. The resident received Hydrocodone-Acetaminophen 11 times for pain ratings ranging from a score of five to ten. Tramadol HCl was given nine times for pain ratings ranging from a score of four to seven. On five days at different times the resident received the Hydrocodone-Acetaminophen and the Tramadol. Review of the nurses' notes from 10/15 to 1/16 documented that the Hydrocodone-Acetaminophen and the Tramadol were given to the resident for complaints of stomach pain. In each case the pain medications were effective in relieving the pain. There was no documentation of the rationale used to determine which pain medication was given. An interview was conducted on 1/21/16 at 9:35 a.m. with LPN (licensed practical nurse) #1. When asked how staff decided which pain medication to administer when there were three ordered, LPN #1 stated, "I usually go with Tylenol first if the resident complains of pain from one to	F 281		

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F 281	Continued From page 8	F 281		

five (on the pain rating scale)." When asked how they determined a resident's pain level if they were unable to state one, LPN #1 stated, "We use a pain aide on our software, we can click on the behaviors (the resident is exhibiting) and get a pain score." When asked how staff knew which pain medication to give based on Resident #2's orders, LPN #1 stated, "We have a policy and procedure. If the pain level is ten I go for the Tramadol."

An interview was conducted on 1/21/16 at 9:40 a.m. with RN (registered nurse) #1. When asked how staff decided which pain medication to administer when there were three ordered, RN #1 stated, "Try Tylenol, the least potent, wait an hour, if the pain is about the same go on to something stronger." When asked how staff decided which pain medication to administer if the resident had MAPAP scheduled to be given twice a day for pain, RN #1 stated, If they're getting Tylenol scheduled and they complain of pain, I would try Norco because it doesn't have Tylenol in it." When RN #1 reviewed the ingredients in Norco and discovered it did contain Tylenol she stated that she would keep track of the amount of Tylenol the resident received so they did not receive too much."

An interview was conducted on 1/21/16 at 9:47 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked how staff knew which pain medication to administer when three pain medications were ordered, ASM #2 stated, "We use non-pharmacological (methods) first, warm rice packs, re-direction (of the resident's attention), someone chatting with them. Typically start with Tylenol first unless had it recently then give Tramadol and then Norco. If

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F 281	Continued From page 9 the pain level is really high (eight to ten), severe pain, we use Norco." When asked if it was in the scope of the nurse's practice to determine which pain medication to administer, ASM #2 stated, "We can call the doctor to change the orders to clarify when to give which pain medication." A telephone interview was conducted on 1/21/16 at 11:30 a.m. with OSM (other staff member) #1, the pharmacist, regarding what process the pharmacist followed if the physician ordered multiple pain medications without specific indications on when to give each medication. OSM #1 stated, "A lot of times our consulting pharmacist will review those medications, it's duplication of therapy and we would narrow it down to see what is needed and what is not needed for pain." A request for the facility's policy on following and clarifying physician's orders was requested from LPN #2, the MDS coordinator on 1/21/16 at 11:35 a.m. On 1/21/16 at 2:45 p.m. LPN #2 stated that the facility did not have that policy. Review of the facility's policy titled, "Pain Management Policy" documented in part, "If non-pharmacological interventions are unsuccessful in alleviating pain, appropriate pain medication will be administered as ordered." There was no guidance as to how to determine which pain medication to administer if the resident had multiple pain medications ordered. On 1/21/16 at 4:10 p.m. ASM #1, the administrator and ASM #2 were made aware of the findings. No further information was provided prior to exit.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 10 *Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a695011.html **Hydrocodone bitartrate and acetaminophen tablets are indicated for the relief of moderate to moderately severe pain. http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b165dffd-1550-4d8d-a8ea-fe83512c34e6 2. The facility staff failed to clarify at what pain level the two different pain medications ordered should be administered for Resident #4. Resident #4 was admitted to the facility on 3/19/91 with a readmission on 7/27/10 with diagnoses that included but were not limited to: dementia, urinary incontinence, pressure ulcers, spastic quadriparesis* and decreased vision. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 10/26/15 coded the resident as moderately impaired cognitively. Section J -- Health Conditions of the MDS coded the resident as receiving pain medication in the past five days. Review of the physician's orders dated 10/21/15 - 1/21/16 documented, "MAPAP (acetaminophen) ** 325MG (milligram) TABLET Give 2 tablet (sic)	F 281		

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F 281	Continued From page 11 every 6 hours as need for elevated Temperature; Discomfort. MAPAP 325MG TABLET Give 2 tablet (sic) by mouth one time a day for Pain. HYDROCODONE/APAP*** 5-325MG TABLET Give 1 tablet by mouth every 4 hours as need for Pain." Review of Resident #4's care plan dated 7/28/11 documented, "The resident has acute pain r/t (related to) spastic quadraparesis (sic) due to organic brain injury. The resident's pain is relieved by: hydrocod (one)/apap5mg/325mg 1-2 tabs (tablets) q (every) 4 hours prn (as needed) and Tylenol 650 mg po (by mouth) qhs (hour of sleep) and q 6 hrs. prn." Review of the 11/15 MAR (medication administration record) documented that Resident #4 received MAPAP every day as ordered. Further review of the MAR revealed documentation that the resident received Hydrocodone three times for pain ratings ranging from five to eight and MAPAP was given four times for pain ratings ranging from one to ten. Review of the 12/15 MAR documented that the resident received MAPAP every day as ordered and the resident received Hydrocodone three times for pain ratings of six to eight and MAPAP two times for pain ratings of two to five. On one occasion the resident received the medications on the same day. Review of the 1/16 MAR documented that the resident received MAPAP every day as ordered and did not receive any other pain medication. Review of the nurse's notes from 11/15 to 1/16 revealed documentation that the resident's pain	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 12 was relieved with the pain medication with the exception of one instance on 12/8/15 when the resident received additional pain medication. An interview was conducted on 1/21/16 at 9:35 a.m. with LPN (licensed practical nurse) #1. When asked how staff decided which pain medication to administer when there were two ordered LPN #1 stated, "I usually go with Tylenol first if the resident complains of pain from one to five (on the pain rating scale)." When asked how they determined a resident's pain level if they were unable to state one, LPN #1 stated, "We use a pain aide on our software, we can click on the behaviors (the resident is exhibiting) and get a pain score." When asked how staff knew which pain medication to give based on Resident #2's orders LPN #1 stated, "We have a policy and procedure. If the pain level is ten I go for the Tramadol." An interview was conducted on 1/21/16 at 9:40 a.m. with RN (registered nurse) #1. When asked how staff decided which pain medication to administer when there were two ordered, RN #1 stated, "Try Tylenol, the least potent, wait an hour, if about the pain is about the same go on to something stronger." When asked how staff decided which pain medication to administer if the resident had MAPAP scheduled to be given twice a day for pain, RN #1 stated, If they're getting Tylenol schedule and they complain of pain, I would try Norco because it doesn't have Tylenol in it." When RN #1 reviewed the ingredients in Norco and discovered it did contain Tylenol she stated that she would keep track of the amount of Tylenol the resident received so they did not receive too much."	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 281	Continued From page 13 An interview was conducted on 1/21/16 at 9:47 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked how staff knew which pain medication to administered when two pain medications were ordered, ASM #2 stated, "We use non-pharmacological (methods) first, warm rice packs, re-direction (of the resident's attention), someone chatting with them. Typically start with Tylenol first unless had it recently then give Tramadol and then Norco. If the pain level is really high (eight to ten), severe pain, we use Norco." When asked if it was in the scope of the nurse's practice to determine which pain medication to administer, ASM #2 stated, "We can call the doctor to change the orders to clarify when to give which pain medication." A telephone interview was conducted on 1/21/16 at 11:30 a.m. with OSM (other staff member) #1, the pharmacist, regarding what process the pharmacist follow if the physician ordered multiple pain medications without specific indications on when to give each one. OSM #1 stated, "A lot of times our consulting pharmacist will review those medications, it's duplication of therapy and we would narrow it down to see what is needed and what is not needed for pain." A request for the facility's policy on following and clarifying physician's orders was requested on 1/21/16 at 11:35 a.m. from LPN #2, the MDS coordinator. On 1/21/16 at 2:45 p.m. LPN #2 stated that the facility did not have that policy. Review of the facility's policy titled, "Pain Management Policy" documented in part, "If non-pharmacological interventions are unsuccessful in alleviating pain, appropriate pain medication will be administered as ordered."	F 281		

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F 281	Continued From page 14 There was no guidance as to how to determine which pain medication to administer if the resident had multiple pain medications ordered. The findings were reviewed on 1/21/16 at 4:10 p.m. with ASM #1, the administrator and ASM #2, the director of nursing. No further information was provided prior to exit. Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Nurses need to approach pain management systematically to understand a client's pain and to provide appropriate intervention....it is necessary to monitor pain on a consistent basis....Assessment of common characteristics of pain helps the nurse form an understanding of the type of pain, its pattern, and types of interventions that may bring relief....Onset and duration....Location....Intensity....Quality....Pain Pattern....Relief Measures....Contributing Symptoms....Pain therapy requires an individualized approach....Nurses administer and monitor interventions ordered by physicians for pain relief and independently use pain-relief measures that complement those prescribed by a physician....Effective communication of a client's assessment of pain and his or her response to intervention is facilitated by accurate and thorough documentation. This communication needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The client is not responsible for ensuring that this information is accurately transmitted. A variety of tools such as a pain flow sheet or diary will help	F 281		

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F 281	Continued From page 15 centralize the information about pain management. *Spastic qudriparesis: Hereditary spastic paraplegia (HSP), also called familial spastic paraparesis (FSP), refers to a group of inherited disorders that are characterized by progressive weakness and spasticity (stiffness) of the legs. Early in the disease course, there may be mild gait difficulties and stiffness. **MAPAP (Tylenol): for the temporary relief of minor aches and pains due to: ¦ Headache ¦ Muscular aches - ¦ Backache ¦ Minor pain of arthritis ¦ The common cold ¦ Toothache - ¦ Premenstrual and menstrual ... ***Hydrocodone bitartrate and acetaminophen tablets are indicated for the relief of moderate to moderately severe pain. http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b165dffd-1550-4d8d-a8ea-fe83512c34e6 ****Lorazepam is indicated for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms. http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=711b60a3-028d-41d4-aa17-8f976e6df23e 3. The facility staff failed to clarify a physician order for notification of the physician for finger stick blood sugar levels for Resident #6. Resident #6 was admitted to the facility on 3/13/15 with a recent readmission on 10/14/15 with diagnoses that included but were not limited to: mitral valve insufficiency, tricuspid valve insufficiency, high blood pressure, chronic kidney disease, dementia with behaviors, Alzheimer's disease, and diabetes. The most recent MDS (minimum data set)	F 281		

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F 281	Continued From page 16 assessment, an admission assessment with an assessment reference date of 10/20/15, coded the resident as having both short and long term memory difficulties and severely 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 and was dependent upon one staff member for locomotion on and off the unit. The physician order dated 10/14/15 documented, "Fasting Blood Glucose (sugar) monitoring, check via finger stick one time a day every Mon (Monday), Wed (Wednesday), Fri (Friday) related to DIAB (diabetes) W/O (without) COMP (complications) NOTIFY MD (doctor) if less than 60 or greater than 300. Call MD if FBS greater than 200 mg/dl (milligrams per deciliter)." The review of the MAR (medication administration record) for November, December and January, documented, Fasting Blood Glucose (sugar) monitoring, check via finger stick one time a day every Mon (Monday), Wed (Wednesday), Fri (Friday) related to DIAB (diabetes) W/O (without) COMP (complications) NOTIFY MD (doctor) if less than 60 or greater than 300. Call MD if FBS greater than 200mg/dl (milligrams per deciliter)." The review of the MARs revealed that the blood sugars were obtained as ordered. There was no blood sugar reading below 60 or greater than 200. An interview was conducted with RN (registered nurse) #1 on 1/21/16 at 11:13 a.m. RN #1 was asked to review the above physician order. RN #1 stated, "That's an ambiguous order, we need to clarify that with the doctor."	F 281		

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F 281	Continued From page 17 An interview was conducted with the director of nursing (DON), ASM (administrative staff member) #2, on 1/21/16 at 11:23 a.m. The DON was asked to review the above physician order. The DON stated, "That's a terrible order. That needs to be clarified." A policy on clarifying physician orders was requested on 1/21/16 at 1:10 p.m. The LPN (licensed practical nurse) #2 returned at 2:45 p.m. stated that the facility did not have a policy on clarifying physician orders. According to Fundamentals of Nursing, 6th edition Potter and Perry, 2005, page 846, "A medication order is required for any medication to be administered by a nurse...If the medication order is incomplete, the nurse should inform the prescriber and ensure completeness before carrying out any medication order." The administrator, ASM #1 and the DON, ASM #2 were made aware of the above findings on 1/21/16 at 1:10 p.m. No further information was provided prior to exit.	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 309	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the physician orders for one of ten residents in the survey sample, Resident #3. The facility staff failed to notify the physician, per the physician orders when Resident #3's blood sugar was greater than 150 mg/dl (milligrams/deciliter) for three months. The findings include: Resident #3 was admitted to the facility on 1/14/13 with a readmission on 4/9/15 with diagnoses that included but were not limited to: dementia, schizophrenia, chronic kidney disease, psychosis, hyperlipidemia, high blood pressure, depression, diabetes and a hip fracture. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/16/15, coded the resident as being cognitively intact 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 required supervision after set up assistance was provided. The review of the physician orders dated, 11/3/15, and signed by the physician on 11/4/15 and then electronically signed on 1/6/16 by the physician, documented, "Fasting Blood Glucose (sugar) Monitoring, check via finger stick one time a day every Mon (Monday), Wed (Wednesday) and Fri (Friday) related to DIAB (diabetes) W/O	F 309	**Criterion 1. – F309** Resident #3 deceased on January 29, 2015 **Criterion 2.** An audit will be conducted of current residents to ensure that physician orders are followed for blood sugars with parameters. Any variances found during the audit will be investigated and physician orders will be clarified as needed. **Criterion 3.** Changes will be made to the computer system to allow greater visibility of the entire physician order, including parameters of physician orders. Licensed nursing staff will be educated on computer system changes and on the importance of following physician orders. **Criterion 4.** DON or designee will audit the charts weekly for residents with orders for blood sugars with parameters for six weeks to ensure that physician orders are followed. Variances will be investigated, will be corrected as necessary, and responsible staff will be reeducated. Any variances identified will be tracked and trended and reported to the QAPI committee for any additional input. **Criterion 5.** March 1, 2016	

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F 309	Continued From page 19 MENTION COMP (COMPLICATIONS); NOTIFY MD (Medical doctor) IF GREATER THAN 150 MG/DL." A review of Resident #3's MARs (medication administration records) for November and December 2015 and January 2016 was conducted. The following blood sugars were documented: November 2015: 11/4/15 - 162 11/6/15 - 159 11/9/15 - 167 11/11/15 - 164 11/13/15 - 187 11/16/15 - 164 11/18/15 - 177 11/20/15 - 173 11/23/15 - 171 11/25/15 - 176 11/27/15 - 162 11/30/15 - 172 December 2015: 12/2/15 - 185 12/4/15 - 169 12/7/15 - 178 12/9/15 - 168 12/11/15 - 176 12/14/15 - 181 12/16/15 - 187 12/18/15 - 170 12/21/15 - 184 12/28/15 - 198 12/30/15 - 201 January 2016: 1/1/16 - 181	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 309	Continued From page 20 1/4/16 - 205 1/6/16 - 214 1/8/16 - 198 1/11/16 - 187 1/13/16 - 199 1/15/16 - 269 1/18/16 - 195 1/20/16 - 179 Review of the nurse's notes from 11/1/15 through 1/20/16 did not reveal any documentation of notification to the physician for the blood sugars as ordered. An interview was conducted with RN (registered nurse) #1 on 1/21/16 at 10:44 a.m. The above physician order was reviewed with RN #1. When asked what she would do with that order if the resident's blood sugar was greater than 150 mg/dl, RN #1 stated, "I'd call the doctor." When asked if she was to call the doctor each time the blood sugar was greater than 150, RN #1 stated, "Yes." When asked how she would communicate with the doctor, RN #1 stated, "We can fax them or email them." RN #1 was asked if the notification to the physician had to be documented and if so where. RN #1 stated, "Yes, it has to be documented in the progress notes." An interview was conducted with the director of nursing (DON), ASM (administrative staff member) #2, on 1/21/16 at 10:47 a.m. The above physician order was reviewed with the DON. When asked what the nurse is expected to do with the order, the DON stated, "If the resident's blood sugar is greater than the 150 we have to notify the doctor." The facility policy, "Diabetic Care Regimen"	F 309		

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F 309	Continued From page 21 documented, "Notify MD (medical doctor), if FSBS (finger stick blood sugar) > (Greater than) 400 with S/S (signs and symptoms) of hyperglycemia or if FSBS < (less than) 50 with S/S of hypoglycemia, unless otherwise noted." In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." The administrator, ASM #1 and DON, ASM #2, were made aware of these findings on 1/21/16 at 1:10 p.m. No further information was provided prior to exit.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 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 ensure adequate supervision and failed to implement interventions to prevent falls per the plan of care	F 323	Past noncompliance: no plan of correction required.	

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F 323	Continued From page 22 for one of ten residents in the survey sample, Resident #3. The facility staff failed to ensure supervision and failed to place a tab alarm, while the resident was in a recliner, and Resident #3 got up, fell and broke her hip. The findings include: Resident #3 was admitted to the facility on 1/14/13 with a readmission on 4/9/15 with diagnoses that included but were not limited to: dementia, schizophrenia, chronic kidney disease, psychosis, hyperlipidemia, high blood pressure, depression, diabetes and a hip fracture. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/16/15, coded the resident as being cognitively intact 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 required supervision after set up assistance was provided. A review of the Significant Change in Status MDS assessment with an ARD of 1/24/15 coded Resident #3 as scoring a 9 out of 15 on the BIMS (brief interview for mental status) indicating she was moderately impaired for cognition. The resident was coded under Section G- Functional Status as requiring extensive assistance of one or more staff members for bed mobility, transfers, toilet use and personal hygiene. She was coded	F 323		

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F 323	Continued From page 23 as requiring limited assistance with one person physically assisting for walking in room, corridor, and locomotion on and off unit. Section G0300. Balance During Transitions and Walking Coded Resident #3 under A. Moving from seated to standing position as not steady, only able to stabilize with human assistance. Under B. Walking (with assistive device if used) Resident #3 was coded as not steady, only able to stabilize with human assistance. Under J1900. Number of Falls Since Admission or Prior Assessment, Resident #3 was coded as having one fall - No injury. Und B. Injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes resident to complain of pain., Resident #3 was coded a 1 (one fall with injury). The nurse's note dated, 3/31/15 at 11:13 p.m. documented, "@ (At) 1930 (7:30 p.m.) client was sitting in her chair in the great room when she got up unassisted and started walking toward another chair. Client lost her balance, stumbled and fell on the floor. Upon assessment, ROM (range of motion) normal in all extremities except ROM very limited in right leg/hip and client c/o (complained of) severe pain, 10 of 10 (a pain scale of 0 - 10, 10 being the worse pain someone has ever been in) with movement. Client was given Norco (pain medication given for moderate to moderately severe pain) (1). Client c/o right foot numbness and inability to move her left (sic) leg/hip. Reassurance given and client encouraged to limit movement until further evaluation completed. (Name of Doctor) notified of incident and order given to transport client to hospital for evaluation of hip r/t (related to) possible fx (fracture). Paperwork completed and	F 323		

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	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 323	Continued From page 24 rescue squad transported client to (Name of Hospital) at 2015 (8:15 p.m.)...Emergency personnel updated on client's pain and reassurance given by emergency personnel for increased comfort measures enroute to hospital. POA (power of attorney) notified." Review of the care plan dated, 1/22/13, with a revision of the care plan on 2/10/15, documented, "Focus: The resident has had an actual fall 2x (times) in past 3 months with no major injury noted due to unsteady gait and weakness." The "Interventions: TAB alarm while in recliner." This intervention was dated initiated on 1/12/15 and created on 2/10/15. A physician order dated, 3/31/15 documented, "Transport client to hospital of choice for evaluation r/t possible hip fx per (Name of Doctor)." Review of the hospital discharge summary dated, 4/9/15, documented, "Discharge Diagnosis: Acute hyperkalemia (higher than normal potassium level in the blood) (2). Acute on chronic kidney failure, Closed displaced fracture of right femoral neck." A request was made for the incident report. The incident report was provided but surveyor was not allowed to have a copy of it. The "Incident/Accident Report" dated, 3/31/15 at 19:30 documented the incident occurred in the facility great room. "Resident's condition before incident/accident: Normal. Resident attempted to get up out of her recliner unassisted and fell. Landed primarily on R (right) hip with injury noted. Limited ROM in R leg noted. Otherwise full ROM noted. Neuro (neurological) status WNL (within normal limits). Resident transferred to (Initials of	F 323		

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MOUNTAIN VIEW NURSING HOME	1776 ELLY ROAD ARODA, VA 22709

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F 323	Continued From page 25 hospital) per MD (medical doctor) orders.....12. Did CNA (certified nursing assistant) have all safety devices properly in place? Yes." The two CNA (certified nursing assistants) documented on the incident/accident report were no longer employed at the facility. The nurse on duty was contacted. An interview was conducted with RN (registered nurse) #3 on 1/21/16 at 10:58 a.m. RN #3 was asked to describe what happened the evening Resident #3 fell, RN #3 stated, "She (Resident #3) was in the great room in the recliner. There was not a lot of activity going on in the great room. (Resident #3) attempted to stand up out of the recliner. I did not witness the fall. She called out for help. She was fairly alert and oriented but has some confusion. She was trying to get a magazine, I believe." When asked if the resident had a tab alarm on while in the chair, RN #3 stated, "From what I can remember, it was not in use at the time of the fall. We had been instructed a few days before that to do without alarms. I guess we didn't update the care plan. The former DON (director of nursing) had instructed the staff to decrease the use of alarms and to monitor her (Resident #3) closely." When asked how far away the staff was at the time of the fall, RN #3 stated, "The staff was at the nurse's station (approximately 25 - 30 feet away from the resident)." An interview was conducted with ASM (administrative staff) #2, the DON on 1/21/16 at 11:26 a.m. The DON was asked to review the care plan in place at the time of the fall. When asked if a tab alarm should have been in place, the DON stated, "If it's there (documented on the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 323	Continued From page 26 care plan) it should have been in place." The DON stated that the previous DON had an initiative to decrease the amount of alarms used at the facility. The DON was asked to provide evidence of the initiative and training of staff regarding it. An interview was conducted with the administrator on 1/21/16 at 11:57 a.m. He informed the survey team that there was no documentation of the plan to decrease alarms for residents. It was the former DON's initiative to decrease alarms in the facility. The facility policy, "Falls: Policy and Procedure" documented, "Falls are a common source of injury and death among the elderly. It is the responsibility of all staff to assist in identifying risk factors and to carry out established plans to minimize falls. Licensed nursing staff will assess clients who experience falls, for injury and identification of new risk factors. Falls will be addressed on the client's care plan." The administrator and director of nursing were made aware of the concern for harm on 1/21/16 at 1:10 p.m. The administrator stated that the facility had identified falls as a concern and started a plan of action on it. The fall occurred under the leadership of the former administrator. He could not locate any action plan implemented by the previous administrator immediately after the fall. The current administrator stated he had identified falls as a concern one month after starting his position and implemented a plan of action. On 1/21/16 at approximately 2:30 p.m. the administrator and director of nursing presented	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 323	Continued From page 27 credible evidence that a five point plan of correction had been put into place. The credible evidence included the following: A staff meeting In - Service date, 7/9/15 documented, "CNA Updates & Inform (information): If your work is complete, you should be sitting and talking with the residents, not at the nurse's station. If you need to chart, try sitting in the great room at a table close to the recliner circle. Make it a habit to glance up and check on the residents frequently, at least between each resident." Plan of Action: Falls Problem Identification: On November 12, 2015 the administrator and DON noted a problem with falls in this facility. Goals: The Goal of this action plan is to eliminate any avoidable falls. Education Provided: On January 7, 2016 staff meeting at 7:00 p.m., all staff were educated by (name of administrator) about falls and the basics of fall prevention. Items discussed were gait belts and their use, locking wheelchairs for transfers, and proper non-skid footwear use. Interventions: All nursing assistants must have a gait belt with them at all times. Gait belts must be used on all transfers and ambulation for which they are appropriate. A falls committee will be researched and developed for future implementation. More education concerning falls and gait belts will be provided at the February 2016 staff meeting. Date of Implementation: January 8, 2016 Evaluation: This will be evaluated through our current QAPI (Quality Assurance Program Improvement) process and the falls committee once that is implemented."	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 323	Continued From page 28 An interview was conducted with CNA #5 on 1/21/16 at 3:00 p.m. When asked how the staff prevents falls, CNA #5 stated, "The first thing is the use of gait belts, using two people assist to walk clients. We have to remember to lock wheelchair prior to transfers." When asked if clients are to be left alone in the great room, CNA #5 stated, "No, there always has to be a CNA in the great room when there are residents present." When asked how a CNA knows what fall interventions are in use for a particular resident, CNA #5 stated, "First our nurse gives us report as does the off going CNA. We can check the care plan for the intervention. We have access to care plan through our charting application on the computer." An interview was conducted with CNA #6, the resident care services CNA, on 1/21/16 at 3:40 p.m. When asked how the facility prevents falls, CNA #6 stated, "The first thing we do is always use a gait belt unless there is an exception that the DON has informed us of." When asked if motion alarms were used as a fall intervention, CNA #6 stated, "The DON makes that determination." When asked where a CNA finds out what interventions are in place to prevent falls for a particular resident, CNA #6 stated, "We have access to the care plan and it's our responsibility to read it for what interventions a resident may need." During the survey, no concerns were identified by observation or record review for falls. The staff was observed using gait belts. When the great room was observed with residents in the room, a staff member was always present. No further information was provided prior to exit.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 323	Continued From page 29 PAST NON - COMPLIANCE (1) <http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1c7ff5b9-6698-4e8c-9060-2abcd3fb0dcf> (2) Barron's Dictionary of Medical Terms for the Non - Medical Reader, 5th edition, Rothenberg and Chapman; page 281.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 329	Continued From page 30 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 ensure a drug regimen free from unnecessary medications for one of ten residents in the survey sample, Resident #4. The facility staff failed to have adequate and appropriate indications for use of Lorazepam for Resident #4. The findings include: Resident #4 was admitted to the facility on 3/19/91 with a readmission on 7/27/10 with diagnoses that included but were not limited to: dementia, urinary incontinence, pressure ulcers, spastic quadriparesis* and decreased vision. The most recent MDS (minimum data set), was an annual assessment, with an ARD (assessment reference date) of 10/26/15 coded the resident as moderately impaired cognitively. Section J -- Health Conditions of the MDS coded the resident as receiving pain medication in the past five days. Review of the 10/21/15 to 1/21/16 physician's orders revealed, "LORAZEPAM**** 1 MG TABLET Give 1 tablet by mouth one time a day related to DEPRESSIVE DISORDER NOT ELSEWHERE CLASSIFIED." Review of Resident #4's care plan revealed documentation that the resident had depression but did not note that the resident had lorazepam ordered.	F 329	**Criterion 1. F-329** Resident #4 order for Lorazepam was clarified with the attending Physician on Feb 5, 2016. Physician changed the indication to a previously diagnosed Anxiety Disorder. **Criterion 2.** Other residents with orders for anxiolytic medications will be audited and reviewed for proper indications, diagnosis and necessary usage. Any variances will be clarified and the physician will be notified for any clarification. **Criterion 3.** Other residents with orders for anxiolytic medications will be audited and reviewed for proper indications, diagnosis and necessary usage. Any variances will be clarified and the physician will be notified for any clarification. **Criterion 4.** The DON or her designee will audit the physician orders for anxiolytic medications in order to ensure proper usage of medications and will validate that there is an appropriate corresponding diagnosis to support the use of the anxiolytic medication. Variances will be investigated; will be corrected, as necessary, and responsible staff will be reeducated. Any variances identified will be tracked and trended and reported to the QAPI committee for any additional input. **Criterion 5.** March 1, 2016	

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	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 329	Continued From page 31 A review of the MAR's (medication administration records) for 11/15, 12/15 and 1/16 documented, "LORAZEPAM 1 MG TABLET Give 1 tablet by mouth at bedtime related to DEPRESSIVE DISORDER." The medication was documented as being given every day. An interview was conducted on 1/21/16 at 9:47 a.m. with ASM (administrative staff member) #2, the director of nursing, regarding what the indications were for the use of lorazepam with Resident #4. ASM #2 stated, "Agitation and anxiety." When asked if lorazepam was used for depression, ASM #2 stated, "I don't think so." ASM #2 was made aware of the findings at that time. A telephone interview was conducted on 1/21/16 at 11:30 with OSM (other staff member) #1, the pharmacist, regarding what the indications were for use of lorazepam. OSM #1 stated. "Anxiety, restlessness and agitation." When asked if lorazepam was used to treat depression, OSM #1 stated, "Let me look it up, I don't see it. I would assume it was not for depression and get clarification on that order if I saw that." An interview was conducted on 1/21/16 at 11:35 a.m. with LPN (licensed practical nurse) #1. When asked what the indication was for giving lorazepam, LPN #1 stated, "Anxiety." When asked if it could be given for depression, LPN #1 stated, "No." On 1/21/16 at 4:10 p.m. ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the findings. No further information was provided prior to exit.	F 329		

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	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334	**Criterion 1. F-334** Education for an influenza vaccination were provided to Residents #1 and #4 or their responsible party on Feb 5, 2016. **Criterion 2.** Other residents who received influenza vaccinations will be audited for consent and education. Any variances will be investigated and education will be provided. **Criterion 3.** Yearly consents will be obtained for influenza vaccinations. Licensed nursing staff will be educated on the new consent and education forms for Influenza vaccinations. **Criterion 4.** DON or designee will audit 50% of the charts for confirmation of consent and education prior to influenza vaccinations being given. Variances will be investigated, will be corrected as necessary, and responsible staff will be reeducated. Any variances identified will be tracked and trended and reported to the QAPI committee for any additional input. **Criterion 5.** March 1, 2016	

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	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 334	Continued From page 33 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide education and obtain consent for influenza vaccination for two of ten residents in the survey sample, Resident #1 and Resident #4. 1. The facility staff failed to provide education and obtain consent for the influenza vaccination given on 10/7/15 for Resident #1.	F 334		

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	49E050	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW NURSING HOME	1776 ELLY ROAD ARODA, VA 22709

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F 334	Continued From page 34 2. The facility staff failed to provide education and obtain consent for the influenza vaccination given on 10/8/15 for Resident #4. The findings include: 1. Resident #1 was admitted to the facility on 2/13/15 with a readmission on 9/13/15 with diagnoses that included but were not limited to: dementia, urinary incontinence, behavior changes and falls. Resident #1's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/13/15 coded the resident as being severely impaired cognitively to make daily decisions. The resident was coded as receiving the influenza vaccination on 10/7/15. A review of the facility's standing orders documented that residents were to receive the influenza vaccination each year. A review of Resident #1's clinical record did not reveal that education had been given or consent obtained for the influenza vaccination given to Resident #1 on 10/7/15. A review of the facility's influenza report documented that Resident #1 consented to receiving the influenza vaccination. On 1/21/16 at 9:25 a.m. the influenza education and consent for Resident #1 was requested. An interview was conducted on 1/21/16 at 2:45 p.m. with ASM (administrative staff member) #2, the director or nursing. When asked the process	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW NURSING HOME	1776 ELLY ROAD ARODA, VA 22709

(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 334	Continued From page 35 for obtaining consent for the influenza vaccination ASM #2 stated, "We explain to the resident about the flu shot." ASM #2 was asked what process staff followed if the resident was not cognitively intact to understand the explanation. ASM #2 stated, "I think we go on the consent signed on admission, I'll double check it." An interview was conducted on 1/21/16 at 2:55 p.m. with LPN (licensed practical nurse) #2, the MDS coordinator. When asked for the consent and education for Resident #1, LPN #2 stated, "There's nothing in the chart." An interview was conducted on 1/21/16 at 3:42 p.m. with ASM #2. ASM #2 stated, "This is all we have (referring to the facility's consent form) and we recognize this is not enough and plan to get consents every year." When asked why they would want to obtain the resident's or responsible party's consent, ASM #2 stated, "We're not supposed to do anything without the resident's or POA's (power of attorney) consent." The facility's policy titled, "Influenza Vaccine Policy" documented, "It is the policy of (name of facility) to inquire upon Influenza vaccination upon admission. It is also our policy to offer the Influenza Vaccination each year to all our residents. We encourage each resident to receive the vaccine per the CDC (centers for disease control) recommendation." The policy did not include education to be given to the resident or that consent was to be obtained. The facility's consent form documented, "Influenza vaccine is offered yearly in the fall for all residents, with the exception of those with a severe allergy to eggs or those who have had a	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW NURSING HOME	1776 ELLY ROAD ARODA, VA 22709

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F 334	Continued From page 36 serious reaction to previous flu shot." 2. The facility staff failed to provide education and obtain consent for the influenza vaccination given on 10/8/15 for Resident #4. Resident #4 was admitted to the facility on 3/19/91 with a readmission on 7/27/10 with diagnoses that included but were not limited to: dementia, urinary incontinence, pressure ulcers, spastic quadriparesis* and decreased vision. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 10/26/15 coded the resident as being moderately impaired cognitively. The resident was coded as receiving the influenza vaccination on 10/8/15. A review of the facility's standing orders documented that residents were to receive the influenza vaccination each year. A review of Resident #4's clinical record did not reveal that education had been given or consent obtained for the influenza vaccination given to Resident #1 on 10/8/15. On 1/21/16 at 9:25 a.m., the influenza education and consent for Resident #4 was requested. An interview was conducted on 1/21/16 at 2:45 p.m. with ASM (administrative staff member) #2, the director or nursing. When asked the process for obtaining consent for the influenza vaccination, ASM #2 stated, "We explain to the resident about the flu shot." ASM #2 was asked what process staff followed, if the resident was	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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MOUNTAIN VIEW NURSING HOME	1776 ELLY ROAD ARODA, VA 22709

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F 334	Continued From page 37 not cognitively intact to understand the explanation. ASM #2 stated, "I think we go on the consent signed on admission, I'll double check it." An interview was conducted on 1/21/16 at 2:55 p.m. with LPN (licensed practical nurse) #2, the MDS coordinator. When asked for the consent and education for Resident #1, LPN #2 stated, "There's nothing in the chart." An interview was conducted on 1/21/16 at 3:42 p.m. with ASM #2, the director of nursing. ASM #2 stated, this is all we have (referring to the facility's consent form) and we recognize this is not enough and plan to get consents every year." When asked why they would want to obtain the resident's or responsible party's consent, ASM #2 stated, "We're not supposed to do anything without the resident's or POA's (power of attorney) consent." The findings were reviewed on 1/21/16 at 3:45 p.m. with ASM #1, the administrator and ASM #2, the director of nursing. No further information was received prior to exit.	F 334		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING _____ B. WING _____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to prepare and serve food in a sanitary manner. Facility staff failed to wear adequate hair restraints and to wear gloves when preparing food serving trays. The findings include: During the kitchen observation on 1/20/16 at 10:00 a.m. three staff were observed in the kitchen. Each staff member had a white kerchief on their head. The kerchief was placed on midway on the top of the head leaving hair exposed at the front of the head and around the ears. Another observation was made on 1/20/16 at 10:45 a.m. of the staff again wearing only the kerchief on their heads each staff member had short hairs loose around their faces. During the kitchen observation on 1/20/16 at 10:45 a.m. OSM (other staff member) #2, the dietary manager, was observed preparing a serving pan. OSM #2 took a large metal serving tray and placed a plastic liner bag in the pan, she then took her bare hands and patted the plastic liner bag into place in the bottom of the pan. OSM #2 then filled the pan with noodles. OSM #2 then took another large metal serving tray and placed the plastic liner bag in the tray and again used her bare hands to place the bag in the pan. OSM #2 then filled the pan with fish.	F 371	**Criterion 1. – F371** Staff were instructed to wear proper hair restraints and gloves at all times while preparing food to insure that food is prepared in a safe and sanitary manner. **Criterion 2.** All residents were potentially impacted. **Criterion 3.** Staff will be required to wear hair nets at all times while preparing food. All kitchen staff will be educated on the importance of sanitary and safe food preparation including the use gloves and hair restraints. **Criterion 4.** The Dietary Manager or her designee will randomly monitor the staff to ensure that gloves and hair restraints are properly worn. Documentation of the monitoring will be maintained for six weeks . Variances will be investigated, will be corrected as necessary, and responsible staff will be reeducated. Any variances identified will be tracked and trended and reported to the QAPI committee for any additional input. **Criterion 5.** March 1, 2016	

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	49E050	A. BUILDING _____ B. WING _____	01/21/2016

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F 371	Continued From page 39 An interview was conducted on 1/20/16 at 1:30 p.m. with OSM #2. When asked about not wearing a hair restraint OSM #2 stated, "We have our hair up and our veils on, we don't cut our hair. I'm curious why no one has said anything until now, I will definitely change things" When asked about the risk of shedding the short hairs around their faces OSM #2 did not have a response. When asked about the handling of serving trays and utensils OSM #2 stated, "We only touch the handles of the utensils, pans and plates we try not to touch the inside where food would be, just the outside." When asked why that was important OSM #2 stated, "So we don't contaminate it." Review of the facility's policy titled, "Hygenic Practices" documented in part, "A.....food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair that are designed and worn to effectively keep their hair from contacting exposed food..." Review of the facility's policy titled, "PREVENTION OF CONTAMINATION" documented in part, "11. Handle foods as little as possible. use utensils, tongs, or wear plastic gloves." Review of the facility's Department of Health Food Inspection report from 6/16/15 documented that there was no observation of food being handled with bare hands. There was no documentation about hair restraints. An interview was conducted on 1/20/16 with ASM (administrative staff member) #1, the administrator. When discussed the lack of hair restraints ASM #1 stated, "They don't cut their	F 371		

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F 371	Continued From page 40 hair, I just thought because their hair is tied back in a bun that they couldn't lose hair in the food." ASM #1 was made aware of the findings. No further information was provided prior to exit.	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. 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 that one of 10 residents in the survey sample was examined by a physician every 60 days, Resident #6. Resident #6 was not seen by a physician from 5/24/15 through 9/24/15, a period of 122 days. The findings include: Resident #6 was admitted to the facility on 3/13/15 with a recent readmission on 10/14/15 with diagnoses that included but were not limited to: mitral valve insufficiency, tricuspid valve insufficiency, high blood pressure, chronic kidney disease, dementia with behaviors, Alzheimer's	F 386	**Criterion 1. – F386** Resident #6 was examined by a physician on 09/24/15. **Criterion 2.** All other residents will be audited to ensure that physicians visit in a timely manner. Any variances will be investigated and physicians will be notified. **Criterion 3.** The DON or designee will maintain a log of physician visits to maintain timely visits. Physicians will be reeducated on the regulations concerning timely physician visits. **Criterion 4.** The DON or designee will audit 50% residents for physician visits every 60 days times six months to ensure timely visits. Variances will be investigated, will be corrected as necessary, and responsible staff will be reeducated. Any variances identified will be tracked and trended and reported to the QAPI committee for any additional input. **Criterion 5.** March 1, 2016	

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F 386	Continued From page 41 disease, and diabetes. The most recent MDS (minimum data set) assessment, an admission assessment with an assessment reference date of 10/20/15, coded the resident as having both short and long term memory difficulties and severely 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 and was dependent upon one staff member for locomotion on and off the unit. Review of the clinical record revealed a physician progress note dated, 5/24/15. The next progress note was dated, 9/24/15. On 1/21/16 at 1:10 p.m. the administrator and director of nursing (DON) were asked if they could locate any physician progress note between 5/24/15 and 9/24/15. A copy of the policy on physician visits was also requested. The LPN (licensed practical nurse) #2 returned on 1/21/16 at 2:45 p.m. and stated that the facility did not have a policy on physician visits. When asked who tracks the physician visits, LPN #2 stated, "I guess the DON." An interview was conducted with the DON, ASM (administrative staff member) #2, on 1/21/16 at approximately 3:45 p.m. When asked who tracks the physician visits, the DON stated, "I guess I do." When asked her process for notifying the physicians that they are due, the DON stated, "We can bring up a list on the computer that tells us when the physician is due to see a resident. The physicians come about once a month. I send them the list prior to them coming to inform	F 386		

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F 386	Continued From page 42 them of the residents that need to be seen that month." When asked what happens when they don't come as scheduled, the DON stated, "I first email them and if they do not respond I follow up with a phone call. This doctor in particular only has one resident here so I will need to have a talk with her and tell her she caused us a deficiency." When asked if they had a policy on physician visits, the DON stated, "No, there is no policy at this time." No further information was provided prior to exit.	F 386		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 520		

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F 520	Continued From page 43 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 demonstrate proof that the director of nursing was in attendance at the quarterly quality assurance meeting for one quarter, the third quarter, July through September 2015. The findings include: The Quality Assurance (QA) review task was conducted on 1/21/16 at 3:52 p.m. with the administrator and director of nursing. The administrator, ASM (administrative staff member) #1, and director of nursing, ASM #2 could not provide evidence that the director of nursing (DON) was in attendance at the QA meeting on 10/16/15 for the third quarter of 2015. A front cover sheet was provided with the heading, "Quality Assurance/Performance Improvement Quarterly Report" with the date of 10/16/15. The DON's name was typed on the cover sheet. The attendance sheet attached to the report did not evidence her signature. The facility policy, "Quality Assurance Committee" documented, "A separate "sign-in" sheet will be maintained with the date of the meeting and Committee member name, title and signature to be provided, as requested, to inspector's or auditors." No further information was provided prior to exit.	F 520	**Criterion 1. – F520** The DON at time of this meeting has since discontinued her employment as of January 8, 2016. **Criterion 2.** QAPI sign in sheets will be audited for proper attendance. Any variances will be investigated and staff members will be educated. **Criterion 3.** QAPI sign in sheets will be maintained for all QAPI meetings. The Administrator will audit for attendance of DON. The current DON will be educated on proper QAPI attendance. **Criterion 4.** The administrator or his designee will audit QAPI attendance. Variances will be investigated, will be corrected as necessary, and responsible staff will be reeducated. Any variances identified will be tracked and trended and reported to the QAPI committee for any additional input. **Criterion 5.** Feb 4, 2016	