STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495368	A. BUILDING _____ B. WING _____	C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEWPORT	11141 WARWICK BLVD NEWPORT NEWS, VA 23601

(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 9/7/16 through 9/9/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 60 certified bed facility was 41 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents #1 through 10) and 4 closed record reviews (Residents #11 through 14).	F 000		
F 164 SS=D	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(e), 483.75(l)(4) The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		10/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/30/2016

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interview, resident interview and facility documentation, the facility staff failed to provide privacy during administration of a Heparin injection for 1 of 14 residents in the survey sample, Resident #8. The findings included: Resident #8 was originally admitted to the facility 5/28/16 and had never been discharged from the facility. The current diagnoses included myasthenia gravis (chronic autoimmune neuromotor disease) and malignant melanoma with metastasis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/4/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #8 cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring limited assistance of 1 person with walking, dressing and eating, and personal hygiene, with extensive assistance of 1 person with bed mobility, transfers, locomotion,	F 164	F 164 This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. 1. Resident #8 was interviewed and was without negative outcomes related to staff failure to provide privacy during the injection. The responsible nurse was re-educated on the importance of providing privacy when administering injections. 2. The responsible nurse was observed during five medication passes to ensure privacy was provided when appropriate. RNs and LPNs were observed during medication administration to ensure privacy was provided when appropriate. 3. RNs and LPNs were re-educated by	

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F 164	Continued From page 2 and toileting, and total care with bathing. The medical record revealed a physician's order for Heparin Sodium injection 5,000 units per one milliliter (ml) subcutaneous (SQ) every 8 hours. The 9/4/16 MDS assessment reveal at section "N300" non-insulin injections were administered seven days per week and at section "N410" the resident received anticoagulants seven days per week. Heparin injection is an anticoagulant. It is used to decrease the clotting ability of the blood and help prevent harmful clots from forming in blood vessels. (http://www.mayoclinic.org/drugs-supplements/heparin-intravenous-route-subcutaneous-route/description/DRG-20068726) During the medication pass and pour observation on 9/7/16 at 5:05 p.m., Resident #8 received Heparin Sodium injection 5,000 units per one ml SQ. LPN #1 was observed bringing the resident's medication to bedside, viewing the identification bracelet to identify the resident, and explaining to the resident it was time to administer the injectable medication as well. The resident rolled her pant down to expose her abdomen, the nurse cleaned the selected site and administered the Heparin. Neither the privacy curtain nor the door was closed and the resident was viewable from the hallway. Three individuals were observed passing by the doorway prior to the completion of the procedure. LPN #1 was asked if it was a desire of the resident not to close the door or the privacy curtain when the abdomen was exposed. LPN #1 stated, "I'll be honest, I forgot" to provide privacy.	F 164	the Nursing Education and Training Coordinator/Designee on "Providing Privacy." The in-service included but was not limited to a review of the medication administration policy and occasions when privacy should be provided during medication administration. 4. The Director of Nursing/ Designee will conduct five random medication pass observation audits weekly for six weeks to ensure privacy is being provided during medication administration. The Director of Nursing will report any trends or patterns to the Continuous Quality Improvement Committee at least quarterly.	

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F 164	Continued From page 3 On 9/7/26 at approximately 5:40 p.m., Resident #8 was asked if it was a common practice for the staff not to provide privacy during administration of the Heparin injection. The resident stated she did not know but it was her preference to not have others looking in when she receives the injection. The facility's policy titled 'Resident Rights' with a revision date of 9/3/02 stated under privacy and confidentiality that privacy will be provided for accommodations, medical treatments, written and telephone communications, personal care, visits and meetings of family and resident groups. The above findings were shared with the Administrator, Director of Nursing and the Corporate nurses on 9/9/16 at approximately 2:15 p.m. No additional information was provided.	F 164		
F 166 SS=D	RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES CFR(s): 483.10(f)(2) A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to resolve grievances for 1 of 14 residents (Resident #4), in the survey sample. Resident #4 stated the facility staff had not followed-up with her after reporting 3 - 4 weeks	F 166	F166 This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is	10/7/16

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F 166	Continued From page 4 ago she was missing $50.00. The findings included: Resident #4 was originally admitted to the facility 5/24/16 and had never been discharged from the facility. The current diagnoses included anemia, hypertension (high blood pressure), chronic kidney disease, hyperlipidemia, hemiparesis (weakness on one side of body), asthma and stroke. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/31/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #4 cognitive abilities for daily decision making were intact. The resident was coded for no mood or behavior problems, requiring extensive assistance of 1 person with bed mobility, transfers, locomotion, dressing, eating, toileting, and personal hygiene and total care with bathing. An interview was conducted with Resident #4 on 9/8/16 at approximately 2:45 p.m. The resident stated she had previously lived in the assisted living unit but approximately June 17, 2016 she had a fall and was sent to the emergency room of a local hospital. She went on to say she stayed at the hospital until Sunday June 19, 2016 under observation. She was not admitted to the hospital. Resident #4 stated she injured the rotator cuff of the "good arm" resulting in her not being able to do as much for herself after the fall. The resident stated the facility staff told her she would have to move from the assisted living unit to the health care facility on June 25, 2016	F 166	an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. 1. The administrator and the social worker interviewed resident #4 upon notification of the grievance. An investigation was immediately initiated per protocol. Facility procedures were followed to address the grievance. The resident was provided the outcome of the investigation. 2. The social worker/designee conducted interviews with residents and staff to ensure any resident grievances had been addressed immediately by the facility. 3. Resident rights and the grievance procedure will be discussed at the next resident forum meeting and will be included as an agenda item at least quarterly in the forum discussion. An in-service will be conducted with facility staff on the facility grievance procedure including reporting all grievances immediately to the Administrator/designee. 4. The Administrator/designee will interview at least 10% of the facility residents weekly for a period of six weeks to ensure any grievances have been reported in a timely manner and addressed according to facility protocol. The administrator/designee will report any trends to the CQI committee at least	

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F 166	Continued From page 5 because of her increased dependence on the staff. Resident #4 stated during the interview on 9/8/16 at approximately 2:45 p.m., she had reported missing money 3 - 4 weeks earlier to a nursing staff member who referred to theirself as "the boss" and no one had followed-up with her concerning the matter. Resident #4 stated often the staff turns their name badges so you can't read their names. The Administrator stated on 9/8/16 at approximately 12:50 p.m., that no one informed her Resident #4 reported missing money and she spends a great deal of time with the resident and the resident did not notify her of the concern. The Administrator began a grievance investigation on 9/8/16 and the resident provided her with the same information she gave the surveyor. A formal investigation was launched. The Administrator stated all staff is trained on reporting possible abuse, mistreatment, neglect and misappropriation. The Administrator also stated when a resident reports missing property the staff is to report to their immediate supervisor (chain of command system) and the concern is forwarded to the appropriate department for follow-up and resolution, then the resident is met with and interventions are suggested and or implemented to prevent further occurrences. The facility's policy titled 'Resident Grievance Procedure' with a revision date of 10/1/08 stated under Definitions : Voiced grievances "- is not limited to a formal, written grievance process but includes a resident's verbalized complaint to facility staff. "Prompt efforts... to resolve" - include facility acknowledgment of	F 166	quarterly.	

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F 166	Continued From page 6 complaints/grievances and actively working towards resolution of that complaints/grievance where possible. Under Procedure the policy states the residents are encouraged to address their concerns first directly with the facility staff most closely related to their concern. Facility staff is encourage to listen to the resident's concern, acknowledge understanding of their concern and make prompt efforts to find a resolution to the concern... Additionally, the facility will maintain a posting within the facility with the names and numbers of federal and state agencies that may additionally assist residents with their concerns/complaints if the resident feels the facility has not adequately resolved their concern. The facility's policy titled 'Resident Abuse Prevention' under Training with a revision date of 5/1/10 stated; staff will be routinely instructed on how to report abuse, mistreatment, neglect and misappropriation or allegations of such and staff will be routinely in-serviced on what constitutes abuse, mistreatment, neglect and misappropriation, and how to identify it... The above findings were shared with the Administrator and Director of Nursing and the Corporate nurses on 9/9/16 at approximately 2:15 p.m. No additional information was provided.	F 166		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.20(d)(3), 483.10(k)(2) The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		10/14/16

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F 280	Continued From page 7 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed for 1 Resident (Resident #3) of 14 in the survey sample to ensure the Care Plan was updated for fall interventions and for non-pharmacological measures (such as back rub, music therapy, position changes) prior to the administration of pain medications. The findings included: Resident #3 was admitted to the facility on 7/2/15. Diagnoses for Resident #3 included but are not limited to Dementia (the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease), Pain, Osteoporosis (a condition that affects especially older women and is characterized by decrease in	F 280	F 280 This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. 1. The care plan for Resident #3 was updated to include attempting non-pharmacological interventions prior to administering PRN pain medications as well as residents preference to decline non-pharmacological interventions prior to receiving prn pain medication at times. An alarm assessment was completed on	

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F 280	Continued From page 8 bone mass with decreased density and enlargement of bone spaces producing porosity and brittleness), and history of falls. Resident #3's Annual Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 7/9/16 coded Resident #3 as having a 13 of 15 score on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the Annual MDS scored Resident #3 as requiring extensive assistance with one staff person assist for Bed Transfers, Dressing, and Toileting. Resident #3's Physician Order included: Acetaminophen* 325 mg (milligrams) (2 tabs) oral as needed every four hours starting 12/10/15. Acetaminophen: Medline Plus documents: used to relieve mild to moderate pain Resident #3's Physician Order included: Tramadol* 50 mg (1 Tab) oral as needed every six hours starting 10/19/15. Tramadol: Medline Plus documents: used to relieve moderate to moderate severe pain Resident #3's August 2016 Medication Administration Record (MAR) documented Resident #3 received Acetaminophen 325 mg on the following dates without receiving non-pharmacological measures prior to the administration: 8/2/16 10:19 a.m. A pain level was documented as 6 of 10. 8/6/16 7:47 a.m. A pain level was not documented. Resident #3's August 2016 MAR documented Resident #3 received Tramadol 50 mg on the following dates without receiving	F 280	Resident #3 and the care plan was updated to reflect current status. 2. The care plans for residents receiving PRN pain medications were reviewed to ensure non-pharmacological interventions prior to pain medication administration has been addressed. Care plans were also reviewed to ensure resident preferences have been addressed as well. The care plans for residents with fall interventions were reviewed to ensure all fall interventions were updated to reflect current status. 3. RNs and LPNs were re-educated by the Nursing Education and Training Coordinator/ Designee on "Care Planning: Fall Interventions and Offering Non-Pharmacological Interventions." The in-service included the importance of ensuring fall interventions are updated to reflect current resident status. Also discussed was the importance of updating the care plan to reflect the types of non-pharmacological measures to be offered prior to administration of PRN pain medication as well as any resident preferences regarding non-pharmacological interventions. 4. The Director of Nursing/ Designee will audit 20% of care plans weekly for six weeks to ensure care plans are updated for fall interventions and non-pharmacological measures to be attempted prior to the administration of PRN pain medications. The Director of	

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F 280	Continued From page 9 non-pharmacological measures prior to the administration: 8/8/16 9:44 a.m. A pain level was documented as 6 of 10. 8/18/16 1;10 p.m. A pain level was documented as 6 of 10. Resident #3's clinical record nursing notes documented the following falls: 4/18/16 Resident found on floor at 10:52 p.m. No injuries were noted at the time of fall. Resident #3 stated that she was trying to get in her wheelchair and it got away from her. 4/22/16 2:39 a.m. Resident #3 found on floor beside her bed. Skin tear to left knee. 7/5/16 Resident #3 found on floor at approximately 5:00 p.m. Resident #3 stated that she was trying to get in bed and did not make it. Skin tear to right lower shin measuring 3 cm (centimeters) by 2 cm. House dressing applied. 7/7/16 12:06 p.m. Resident #3 found on floor by Certified Nursing Assistant (CNA). Resident #3's wheel chair was observed in the middle of the room and Resident #3 appeared to have fell forward out of wheel chair and hit her head. Resident #3 stated that she must have fallen asleep and fell out of her wheel chair. Resident #3 sustained 2 skin tears from the fall. Midline forehead 0.3 cm by 0.2 cm and Left Upper arm 3.1 cm by 2.1 cm. House treatment applied. 7/30/16 12:20 a.m. Resident #3 found on floor in bathroom sitting beside her toilet. Resident #3 stated, "I scooted from my bed to the bathroom." No acute injury was noted. Resident #3's current Care Plan documented the following problems: (no date was documented on the Care Plan) Potential for pain: with the following interventions	F 280	Nursing/ Designee will report any trends or patterns to the Continuous Quality Improvement committee at least quarterly.	

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but not limited to all interventions.
Encourage and assist to identify intensity, quality, and location of pain.
Encourage to tell nurse when pain interventions are not being effective.
Assist with positioning for comfort- resident refuses to off load pressure areas and prefers to lay on back.
Resident #3's current Care Plan documented the following problem: (No date was documented for this problem)
Potential for injury related to falls. Requires reminders to call for assistance. Unsafe behavior. Requires staff assistance for transfers. History of falls.
Interventions included for this problem included but are not limited to the following:
Resident with fall on 7/3/15; resident re-educated on calling for staff assistance for transfers.
Resident wishes to maintain her independence and does not always call for staff assistance.
8/5/15 - assess need for bed alarm to remind resident not to get up without assistance.
Resident receives therapy to gain strength and maintain independence.
10/17/15 - resident lowered self to floor in bathroom. Resident noncompliant with asking for assistance. Listen to patient's reasons for noncompliance. Active listening may reveal concerns not clearly stated in words and helps individualize teaching process.
12/23/15 Remind resident to lock wheelchair brakes before transferring self.
3/6/16 Apply non-slip mat under wheelchair cushion to keep cushion from sliding when resident is in wheelchair.
7/7/16: resident to request to go to bed if feeling sleepy and staff to encourage resident to go to bed if noted to be sleepy or tired.

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The current Care Plan does not document if Resident #3 is to use bed or chair alarms related to the 8/5/15 intervention: - assess need for bed alarm. Review of the clinical record did not reveal that an assessment for chair alarms had been completed.

9/8/16 at approximately 2:30 p.m. Resident #3 was observed lying in her bed with nasal oxygen at 2 liters per minute. Resident #3 was well groomed. Call bell was within Resident #3's reach.

9/9/16 at approximately 8:20 a.m. Resident #3 was observed sitting in her wheelchair in her room. Her call light was within her reach. Resident #3 had on non-slip shoes.

9/9/16 at approximately 12:15 p.m. Resident #3 was observed lying in her bed. She was going to have peri-care performed and have her brief changed as she was soiled. Resident #3 declined an observation of care by the surveyor.

The Unit Manager #1 stated on 9/9/16 at approximately 9:50 a.m., "She had a chair alarm at one time. She wouldn't want an alarm." The Unit Manager #1 stated, "she always wants a pain pill before getting up and doesn't want a non-pharmacological measure. I don't see where this is care planned. The ADON (Assistant Director of Nursing) updates the care plans."

The ADON (Assistant Director of Nursing) #2 stated on 9/9/16 at approximately 11:30 a.m., "I can't see that she (Resident #3) had an assessment for chair alarm. The Care Plan doesn't show the Resident's need for pain meds

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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 280	Continued From page 12 when she gets out of bed. I can update it now." The facility policy titled, "Comprehensive Care Plan" revised on 4/23/12, documents the following: The care plan is reviewed and updated at least quarterly, with any significant changes, and as needed. The facility policy titled, "Fall Prevention Program" revised on 5/6/11, documented the following: Care plans should reflect the incident and the approaches. The facility policy titled, "Pain Management" revised on 6/15/12, documented the following: The pain management plan of care should include both pharmacological and non-pharmacological interventions developed by the interdisciplinary team. The facility administration was informed of the findings during a meeting on 9/9/16 at approximately 12:45 p.m. The facility did not present any further information about the findings.	F 280		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		10/14/16

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	495368	A. BUILDING _____ B. WING _____	C 09/09/2016

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F 309	Continued From page 13 Based on observation, staff interviews, resident interview, clinical record review and facility document review the facility staff failed to provide non-pharmacological interventions prior to the administration of as needed (PRN) pain medications for 2 of 14 residents (Resident #8 and 3), in the survey sample. The findings included: 1. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) Dilaudid for Resident #8. Resident #8 was originally admitted to the facility 5/28/16 and had never been discharged from the facility. The current diagnoses included myasthenia gravis and malignant melanoma with metastasis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/4/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #8 cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring limited assistance of 1 person with walking, dressing and eating, and personal hygiene, with extensive assistance of 1 person with bed mobility, transfers, locomotion, and toileting, and total care with bathing. In section "J" (Pain Management) the resident was coded as receiving scheduled pain medications and PRN pain medication as well as stating she experienced frequent pain which had affected	F 309	F309 This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. 1. Residents #3 and #8 were assessed and noted to be without negative outcomes related to receiving PRN pain medication prior to offering non-pharmacological interventions. The PRN pain medication order for resident #8 was updated with a monitoring guide to ensure documentation of non-pharmacological interventions are offered prior to administering PRN pain medication. The responsible nurse was re-educated on the importance of offering non-pharmacological interventions prior to PRN pain medication administration. 2. The Director of Nursing/Designee reviewed the records of residents receiving PRN pain medication for the past 30 days to ensure non-pharmacological interventions were offered and documented prior to administration of PRN pain medications. The medication nurse will be responsible for offering non-pharmacological interventions prior to administering PRN pain medications and documenting attempts.	

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F 309	Continued From page 14 sleep at night and was rated at "8" out of a 0 - 10 pain scale. with 10 being the worst pain you can imagine. The active care plan dated 5/28/16 had a problem which read: Potential for pain. The goal read (resident's name) will have pain relieved. The interventions included: Administer medication as prescribed, Encourage and assist resident to identify intensity, quality and location of pain. Encourage resident to tell nurse when pain interventions are not effective. Report to physician when medications or other interventions are not effective. Provide therapy consult as ordered by a physician. Assist resident with positioning for comfort. The physician orders for pain management included: Dilaudid 4 milligrams (mg) 1 tablet by mouth every 6 hours as needed or 2 tablets every 6 hours as needed for severe pain. Dilaudid is a centrally acting pain medication of the opioid class. It is a derivative of morphine. On 9/7/16 during the medication pass and pour observation Licensed Practical Nurse (LPN) # 1 administered one Dilaudid tablet along with the 4 p.m. - 6 p.m. scheduled medications. LPN #1 stated the resident had asked a Certified Nursing Assistant (CNA) to tell him that she wanted pain medication. LPN #1 stated the resident rated the pain as "4" therefore; only one tablet would be administered. LPN #1 was asked if non-pharmacological interventions were offered and attempted and he said "no". When asked if any non-pharmacological interventions that had been used and determined to be effective he stated the compresses provided by the	F 309	3. RNs and LPNs were re-educated on "Non-Pharmacological Interventions Prior to Pain Medications" by the Nursing Education and Training Coordinator/Designee. The in-service included a review of different types of non-pharmacological interventions that may be attempted prior to administering PRN pain medication and importance of documenting non-pharmacological interventions offered prior to PRN pain medication administration. 4. The Director of Nursing/Designee will audit 20% of residents receiving PRN pain medication on a weekly basis for six weeks to ensure documentation supports attempts of non-pharmacological interventions prior to administration of PRN pain medication when appropriate. The Director of Nursing/Designee will identify any patterns or trends and report result to the Continuous Quality Improvement Committee at least quarterly.	

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rehabilitation department and family visits are effective as well as assisting the resident not to stay in a position for prolonged periods of time.

The above information was shared with the Director of Nursing (DON) on 9/8/16 at approximately 1:00 p.m. The DON stated the expectation is for the nurse to assess the resident and offer non-pharmacological interventions prior to PRN pain medication administration.

The facility's policy titled "Pain Management" with a revision date of 6/15/12 stated under Guidelines at bullet #5 "The pain management plan of care should include both pharmacological and non-pharmacological interventions developed by the interdisciplinary team."

The above findings were shared with the Administrator, Director of Nursing and the Corporate nurses on 9/9/16 at approximately 2:15 p.m. No additional information was provided.

2. Resident #3 was admitted to the facility on 7/2/15. Diagnoses for Resident #3 included but are not limited to Dementia (the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease), Pain, Osteoporosis (a condition that affects especially older women and is characterized by decrease in bone mass with decreased density and enlargement of bone spaces producing porosity and brittleness), and History of falls.

Resident #3's Annual Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 7/9/16 coded Resident #3 as having a 13 of 15 score on the Brief

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Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the Annual MDS scored Resident #3 as requiring extensive assistance with one staff person assist for Bed Transfers, Dressing, and Toileting.

Resident #3's August 2016 Medication Administration Record (MAR) documented Resident #3 received Tramadol 50 mg on the following dates without receiving non-pharmacological measures prior to the administration.
8/8/16 9:44 a.m. A pain level was documented as 6 of 10.
8/18/16 1;10 p.m. A pain level was documented as 6 of 10.
No documentation reviewed indicating Resident declined non-pharmacological measures offered.

Resident #3's current Care Plan documented the following problem: (no date was documented on the Care Plan)
Potential for pain: with the following interventions but not limited to all interventions.
Encourage and assist to identify intensity, quality, and location of pain.
Encourage to tell nurse when pain interventions are not being effective.
Assist with positioning for comfort- resident refuses to off load pressure areas and prefers to lay on back.

9/8/16 at approximately 2:30 p.m. Resident #3 was observed lying in her bed with nasal oxygen at 2 litters per minute. Resident #3 was well groomed. Call bell was within Resident #3's reach.

9/9/16 at approximately 8:20 a.m. Resident #3

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F 309	Continued From page 17 was observed sitting in her wheelchair in her room. Her call light was within her reach. Resident #3 had on non-slip shoes. 9/9/16 at approximately 12:15 p.m. Resident #3 was observed lying in her bed. She was going to have peri-care performed and have her brief changed as she was soiled. The Unit Manager #1 stated on 9/9/16 at approximately 9:50 a.m. The Unit Manager #1 stated, "she always wants a pain pill before getting up and doesn't want a non-pharmacological measure. No, I don't see where this is care planned. The ADON (Assistant Director of Nursing) updates the care plans." The ADON (Assistant Director of Nursing) #2 stated on 9/9/16 at approximately 11:30 a.m., "The Care Plan doesn't show the Resident's need for pain meds when she gets out of bed. I can update it now. I see she (Resident #3) didn't receive non-pharmacologicals on the dates." The facility policy, titled, "Pain Management" revised on 6/5/12, documented the following: The pain management plan of care should include both pharmacological and non-pharmacological interventions developed by the interdisciplinary team. The facility administration was informed of the findings during a meeting on 9/9/16 at approximately 12:45 p.m. The facility did not present any further information about the findings.	F 309		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.60(b), (d), (e)	F 431		10/14/16

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F 431	Continued From page 18 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to ensure	F 431	F 431	

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F 431	Continued From page 19 that only authorized staff, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable Law were allowed access to the medication storage room. The findings included: On 9/7/16 at approximately 6:10 p.m., Licensed Practical Nurse (LPN) #30 was asked to escort the surveyors into the medical supply room for inspection of the stored medications. LPN #30 stated the key had to be obtained from the other nurse because it was being used by him. LPN #30 asked LPN #1 for the key to the medication room but it was not in his possession. Assistant Director of Nursing (ADON) #1 stated the Certified Nursing Assistant (CNA) #25 had the keys which opened the medication room because the key to the supply closet was also on the key ring and items needed to be retrieved by CNA #25 from the supply closet. ADON #1 went to the end of the hallway and obtained the key from 1 of 3 CNAs in the supply closet. On 9/7/16 at approximately 6:30 p.m., ADON #1 stated the nurse did wrong giving CNA #25 the key to the supply closet which included the medication room key and the controlled drugs lock box key. ADON #1 further stated CNA #25 was not authorized to administer medications in compliance with Applicable Law. The facility policy titled 'Pharmacy Services' with a revision date of 9/3/03 stated under Storage of drugs that only authorized personnel are permitted to have access to the medication keys ...	F 431	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. 1. The keys to the medication refrigerator and the controlled drug lock box were removed from the charge nurse keys and placed on the medication nurse key ring. Staff were re-educated on ensuring that keys allowing access to medications are in the possession of only personnel authorized to administer medications at all times. 2. The Director of Nursing/Designee has observed staff on the unit to ensure the keys enabling access to medications were in the possession of personnel authorized to administer medications at any given time. 3. RNs and LPNs were re-educated by the Nursing Education and Training Coordinator/Designee on "Medication Keys." The in-service included a review of State and Federal laws permitting only authorized personnel access to the keys which provide access to medications. It included a review of personnel categories who are allowed access to the keys. 4. The Director of Nursing/ Designee will conduct five random checks weekly for six	

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F 431	Continued From page 20 The above information was shared with the Director of Nursing (DON) on 9/8/16 at approximately 5:50 p.m. The DON stated only Registered Nurses and LPNs are authorized to manage the medication storage room keys. The above findings were shared with the Administrator, Director of Nursing and the Corporate nurses on 9/9/16 at approximately 2:15 p.m. No additional information was provided.	F 431	weeks to ensure compliance with State and Federal laws permitting only authorized personnel access to the medication keys. The Director of Nursing/ Designee will report any trends or patterns to the Continuous Quality Improvement committee at least quarterly.	