STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	R 05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments An unannounced Medicare/Medicaid revisit to the Medicare/Medicaid standard survey conducted 3/14/19, and the federal monitoring survey conducted 4/26/19, was conducted 5/28/19 through 5/30/19. The Emergency Preparedness survey was conducted April 22,2019 through April 26, 2019. The facility was found to be in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the Medicare/Medicaid standard survey conducted 3/14/19, and the federal monitoring survey conducted 4/26/19, was conducted 5/28/19 through 5/30/19. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. New deficiencies are identified within this report. The census in this 120 certified bed facility was 108 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 4 closed record reviews.	{F 000}		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		6/13/19

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

Electronically Signed | 06/13/2019

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 686	Continued From page 1 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide the necessary treatment and services, consistent with professional standards of practice, to promote healing of pressure injury for one of 22 residents in the survey sample, Resident #118. The facility staff failed to evidence that pressure injury treatment was provided to Resident #118 per the physician's order on 12/24/18 and 1/5/19. The findings include: Resident #118 was admitted to the facility on 12/21/18. Resident #118's diagnoses included but were not limited to paralysis, diabetes and heart failure. Resident #118's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/28/18, coded the resident as being cognitively intact. Section G coded Resident #118 as requiring extensive assistance of two or more staff with bed mobility/transfers and as requiring extensive assistance of one staff with dressing, personal hygiene and eating. Section M documented Resident #118 was admitted to the facility with one unstageable pressure injury (1). Resident #118's admission skin assessment dated 12/21/18 documented the resident presented with a pressure area on the coccyx (tailbone) that was open and about three	F 686	The Laurels of Willow Creek wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is June 13, 2019. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. 1. Resident #118 no longer resides in facility. 2. All residents requiring wound care for a pressure ulcer have the potential to be affected by this alleged deficient practice. Audit was conducted on current residents receiving wound care to assure compliance with documentation. 3. All licensed nurses will be educated on appropriately completing and documenting all treatments on the TAR. 4. DON or designee will audit 100% of TARs for any resident requiring wound care for pressure ulcers 5 times a week for 2 weeks, then 3 times a week for 2 weeks and then weekly for 2 weeks to	

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F 686	Continued From page 2 centimeters in size. Review of Resident #118's clinical record revealed a physician's order dated 12/22/18 to cleanse the area to buttocks (same area) with normal saline, apply medihoney (2) and an allevyn foam dressing (3) every evening. Review of Resident #118's December 2018 TAR (treatment administration record) failed to reveal evidence that the treatment was administered on 12/24/18 (as evidenced by a blank space on the TAR). Review of December 2018 nurses' progress notes and wound care physician notes failed to reveal documentation that the treatment was administered on 12/24/18. Further review of Resident #118's clinical record revealed a physician's order dated 1/3/19 to cleanse the area to the sacrum (same area) with normal saline, apply silver alginate (4) to the wound bed and cover with a dry dressing twice a day. Review of Resident #118's January 2019 TAR failed to reveal evidence that the treatment was administered once during the evening shift on 1/5/19 (as evidenced by a blank space on the TAR). Review of January 2019 nurses' progress notes and wound care physician notes failed to reveal documentation that the treatment was administered on the evening shift on 1/5/19. Resident #118's comprehensive care plan revised on 12/27/18 documented, "(Name of Resident #118) is at risk for impaired skin integrity/pressure injury R/T (related to): Actual impaired skin integrity/pressure injury...Treatment as indicated..." The nurse who cared for Resident #118 when the treatment was due on 12/24/19 no longer worked	F 686	ensure that treatments have been completed and documented as ordered. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility□s QA committee for 3 months. 5. Corrective action will be completed by 6/13/19	

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F 686	Continued From page 3 at the facility. On 5/29/19 at 1:32 p.m., an interview was conducted with LPN (licensed practical nurse) #2 (the nurse who cared for Resident #118 on 1/19/19 when the left knee treatment was due to be administered). LPN #2 was asked how nurses evidence treatment administration. LPN #2 stated the treatment should be dated and initiated and signed off on the treatment record. LPN #2 was asked what is meant if a physician ordered, treatment is not signed off on the treatment record. LPN #2 stated that hopefully the nursing staff should have gone back to ensure the treatment was not missed. LPN #2 stated usually a progress note is documented if a treatment is changed or discontinued and the nurses usually try to communicate with each other during the shift change. LPN #2 stated the nurse could be called and asked if she completed and signed off on the treatment. LPN #2 was made aware she did not sign off the completion of Resident #118's pressure injury treatment on 1/5/19. LPN #2 stated she could not recall if she completed the treatment or not. On 5/30/19 at 8:15 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "MEDICATION ADMINISTRATION" documented, "All medications and treatments shall be initiated, administered, and/or discontinued in accordance with written physician orders..." No further information was presented prior to exit.	F 686		

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F 686	Continued From page 4 (1) "Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed." This information was obtained from the website: https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (2) Medihoney is used to treat wounds. This information was obtained from the website: http://www.dermasciences.com/medihoney-product-application (3) Allevyn foam is used to treat wounds. This information was obtained from the website: https://www.smith-nephew.com/key-products/advanced-wound-management/allevyn/allevyn-adhesive/ (4) Silver alginate is used to treat wounds. This information was obtained from the website:	F 686		

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F 686	Continued From page 5 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4486446/	F 686		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:	F 755		6/13/19

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F 755	Continued From page 6 Based on staff interview, clinical record review, and facility documentation review, facility staff failed to obtain and provide physician ordered medications for one of 22 sampled residents, Resident #119. The facility staff failed to obtain the ordered Brovana, Forteo, and Restasis from the pharmacy for administration to Resident #119 as ordered by the physician. The findings include: Resident #119 was admitted to the facility on 04/07/2019. Her diagnoses included, but were not limited to, Hypertension (high blood pressure), Chronic Congestive Heart Failure (1), and Chronic Obstructive Pulmonary Disease (2). Resident #119's most recent Minimum Data Set (MDS) Assessment was an Admission Assessment with an Assessment Reference Date (ARD) of 04/09/2019. The Brief Interview for Mental Status (BIMS) was not documented in the MDS assessment. Resident #119's closed record was reviewed as part of a complaint investigation during a revisit survey conducted from 05/28/2019 to 05/30/2019. In support of the complaint investigation, an interview was conducted on 05/29/2019 at 3:20p.m., with RN #1 regarding Resident #119's discharge from the facility. During this interview, RN #1 stated that Resident #119 had not received all of her ordered medications. When asked to clarify what she meant, as the facility Medication Administration Record (MAR) for Resident #119 indicated that all ordered medications were given. RN #1 stated, pointing at the first medication, Brovana (3), "I remember very clearly that we did	F 755	1. Resident #119 no longer resides in facility. 2. All residents have the potential to be affected by this alleged deficient practice. Audit completed on current residents receiving medications to ensure they have been obtained from the pharmacy and are being administered per physician orders. 3. All licensed nurses will be educated on the procedure for obtaining medications from the pharmacy. 4. DON or designee will audit medications for new admissions 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 4 weeks to ensure medications have been obtained from the pharmacy and are being administered per physician orders. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility's QA committee for 3 months. 5. Corrective action will be completed by 6/13/19	

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F 755	Continued From page 7	F 755		

not have that one in the building, because it needed to be pre-authorized before the pharmacy could deliver it." RN #1 went on to indicate two more medications, Forteo (4) and Restasis (5), which she stated were incorrectly documented as given despite being unavailable. RN #1 stated that throughout Resident #119's stay, she (RN #1) was in frequent contact with the Pharmacy trying to acquire the three medications.

A review of Resident #119's Physician Orders revealed the following:

Forteo Solution 600mcg (micrograms)/2.4ml (milliliters) (Teriparatide (Recombinant)) Inject 20mcg subcutaneously (below the skin) one time a day for Osteoporosis Start Date 04/08/2019 0900 (9:00am) End Date 04/09/2019 1734 (5:34pm).

Brovana Nebulization Solution 15mcg/2ml (Arformoterol Tartrate) 1 applicator inhale orally via nebulizer two times a day for SOB (shortness of breath) Start Date 04/07/2019 2100 (9:00pm) End Date 04/08/2019 1221 (12:21pm)

Brovana Nebulization Solution 15mcg/2ml (Arformoterol Tartrate) 1 applicator inhale orally via nebulizer two times a day for SOB (shortness of breath) Start Date 04/08/2019 2100 (9:00pm) End Date 04/09/2019 1734 (5:34pm)

Restasis Emulsion 0.05% (cycloSPORINE) Instill 1 drop in both eyes two times a day for DRY EYES Start Date 04/07/2019 1700 (5:00pm) End Date 04/09/2019 1734 (5:34pm)

A review of Resident #119's MAR revealed that Brovana was marked as given at 9:00p.m., on

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F 755	Continued From page 8 04/07/2019, at 9:00a.m., on 04/08/2019, and at 9:00a.m., on 04/09/2019. The dose for 9:00p.m., on 04/08/2019 was marked as Held. The Forteo was marked as given on 04/08/2019 and 04/09/2019, both at 9:00a.m. The Restasis was marked as given at 9:00p.m., on 04/07/2019, at 9:00a.m., on 04/08/2019, and at 9:00a.m., on 04/09/2019. The dose for 9:00p.m., on 04/08/2019 was marked as Held. The Pharmacy Manifest for all of Resident #119's medications was requested. Review of that document revealed that none of the three medications above were recorded as delivered during Resident #119's stay at the facility. One medication, the Brovana, was marked as delivered on 04/09/2019 at 10:25p.m., many hours after Resident #119 was discharged home. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were informed of the findings at the end of day meeting on 05/30/2019, no further documentation was provided.	F 755		
F 842 SS=D	COMPLAINT DEFICIENCY Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		6/13/19

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F 842	Continued From page 9 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when	F 842		

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F 842	Continued From page 10 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, facility staff failed to maintain a complete and accurate clinical record for three of 22 residents in the survey sample, Resident #119, Resident #121, and Resident #103. The findings include: 1. The facility staff documented medications as administered to Resident #119 when the medications were not available for administration as ordered by the physician. Resident #119 was admitted to the facility on 04/07/2019. Her diagnoses included, but were not limited to, Hypertension (high blood pressure), Chronic Congestive Heart Failure (1), and Chronic Obstructive Pulmonary Disease (2). Resident #119's most recent Minimum Data Set (MDS) Assessment was an Admission	F 842	1. Residents #119 no longer resides in facility. Resident #121 has been receiving Vimpat as prescribed. Resident #103 has had ADL documentation completed daily. 2. All residents have the potential to be affected by this alleged deficient practice. Audit was completed on current residents for past 7 days to assure that ADLs have been documented. Audit completed on current residents receiving medications for past 7 days to ensure they are available and being administered as ordered. 3. All licensed nurses will be educated on properly documenting the administration of medications on the MARs. All nursing assistants will be educated on properly documenting guests' ADLs daily. 4. Random medication administration audits will be observed 5 times a week for	

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F 842	Continued From page 11 Assessment with an Assessment Reference Date (ARD) of 04/09/2019. The Brief Interview for Mental Status (BIMS) was not documented in the MDS assessment. An interview was conducted on 05/29/2019 at 3:20p.m., with RN #1 regarding Resident #119's discharge from the facility. During this interview, RN #1 stated that Resident #119 had not received all of her ordered medications. When asked to clarify what she meant, as the facility Medication Administration Record (MAR) for Resident #119 indicated that all ordered medications were given. RN #1 stated, pointing at the first medication, Brovana (3), "I remember very clearly that we did not have that one in the building, because it needed to be pre-authorized before the pharmacy could deliver it." RN #1 went on to indicate 2 more medications, Forteo (4) and Restasis (5), which she stated were incorrectly documented as given despite being unavailable. RN #1 stated that throughout Resident #119's stay, she (RN #1) was in frequent contact with the Pharmacy trying to acquire the three medications. A review of Resident #119's Physician Orders revealed the following: Forteo Solution 600mcg (micrograms)/2.4ml (milliliters) (Teriparatide (Recombinant)) Inject 20mcg subcutaneously (below the skin) one time a day for Osteoporosis Start Date 04/08/2019 0900 (9:00am) End Date 04/09/2019 1734 (5:34pm). Brovana Nebulization Solution 15mcg/2ml (Arformoterol Tartrate) 1 applicator inhale orally via nebulizer two times a day for SOB (shortness of breath) Start Date 04/07/2019 2100 (9:00pm)	F 842	1 week, then 3 times a week for 2 weeks and then weekly for 2 weeks to ensure that medications are available and being administered as ordered. ADL documentation will be audited 5 times a week for 1 week, then 3 times a week for 2 weeks and then weekly for 2 weeks to ensure ADLs have been documented. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits during the clinical operations meeting and will be reported to the facility□s QA committee for 3 months. 5. Corrective action will be completed by 6/13/2019	

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	495257	A. BUILDING _____ B. WING _____	R 05/30/2019

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F 842	Continued From page 12 End Date 04/08/2019 1221 (12:21pm) Brovana Nebulization Solution 15mcg/2ml (Arformoterol Tartrate) 1 applicator inhale orally via nebulizer two times a day for SOB (shortness of breath) Start Date 04/08/2019 2100 (9:00pm) End Date 04/09/2019 1734 (5:34pm) Restasis Emulsion 0.05% (cycloSPORINE) Instill 1 drop in both eyes two times a day for DRY EYES Start Date 04/07/2019 1700 (5:00pm) End Date 04/09/2019 1734 (5:34pm) A review of Resident #119's MAR revealed that Brovana was marked as given at 9:00p.m., on 04/07/2019, at 9:00a.m., on 04/08/2019, and at 9:00a.m., on 04/09/2019. The dose for 9:00p.m., on 04/08/2019 was marked as Held. The Forteo was marked as given on 04/08/2019 and 04/09/2019, both at 9:00a.m. The Restasis was marked as given at 9:00p.m., on 04/07/2019, at 9:00a.m., on 04/08/2019, and at 9:00a.m., on 04/09/2019. The dose for 9:00p.m., on 04/08/2019 was marked as Held. Review of the Resident #119's Pharmacy Manifest for all of medications document revealed that none of the three above medications were recorded as delivered during Resident #119's stay at the facility. One medication, the Brovana, was marked as delivered on 04/09/2019 at 10:25p.m., many hours after Resident #119 was discharged home. The facility staff indicated that their Nursing Standard was "Lippincott". The following is found in "Lippincott Nursing Procedures 6th Edition", page 230: "Documentation is the process of preparing a complete record of a patient's care	F 842		

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F 842	Continued From page 13	F 842		

and is a vital tool for communication among health care team members. Accurate, detailed charting shows the extent and quality of the care that nurses provide the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors."

A review of the facility policy on Medication Administration revealed in part the following: "9. Administer the medication. (Note: remain with the guest while administering oral medications to verify their consumption).
10. Initial the guest's Medication Administration Record (MAR) immediately following administration.
11. Record any medication omissions including date, time, and reason on the back of the Medication Administration Record (MAR). .."

ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) were informed of the findings at the End of Day meeting on 05/30/2019. No further documentation was provided.

COMPLAINT DEFICIENCY

1. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. - https://medlineplus.gov/heartfailure.html

2. COPD (chronic obstructive pulmonary disease)

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F 842	Continued From page 14 makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. At first, COPD may cause no symptoms or only mild symptoms. As the disease gets worse, symptoms usually become more severe. - https://medlineplus.gov/copd.html 3. Arformoterol inhalation is used to control wheezing, shortness of breath, coughing, and chest tightness caused by chronic obstructive pulmonary disease (COPD; a group of lung diseases, which includes chronic bronchitis and emphysema). Arformoterol is in a class of medications called long-acting beta agonists (LABAs). It works by relaxing and opening air passages in the lungs, making it easier to breathe. - https://medlineplus.gov/druginfo/meds/a607061.html 4. Teriparatide injection is used to treat osteoporosis (a condition in which the bones become thin and weak and break easily) in men and in women who have undergone menopause ('change in life,' end of menstrual periods), who are at high risk of fractures (broken bones). This medication is also used to treat osteoporosis in men and women who are taking corticosteroids (a type of medication that may cause osteoporosis in some patients). Teriparatide injection contains a synthetic form of natural human hormone called parathyroid hormone (PTH). It works by causing the body to build new bone and by increasing bone strength and density (thickness). -	F 842		

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F 842	Continued From page 15 https://medlineplus.gov/druginfo/meds/a603018.html 5. Ophthalmic cyclosporine is used to increase tear production in people with dry eye disease. Cyclosporine is in a class of medications called immunomodulators. It works by decreasing swelling in the eye to allow for tear production. - https://medlineplus.gov/druginfo/meds/a604009.html 2. The facility staff documented medications as administered to Resident #121 when the medications were not administered as ordered by the physician. Resident #121 was admitted to the facility on 02/12/2019. His diagnoses included, but were not limited to, hip replacement, dementia, hypertension (high blood pressure), and hyperlipidemia (high blood cholesterol). Resident #121's most recent Minimum Data Set (MDS) Assessment was a Significant Change Assessment with an Assessment Reference Date (ARD) of 04/16/2019. The Brief Interview for Mental Status (BIMS) scored Resident #121 at 11, indicating mild impairment. On 05/30/2019, an interview was conducted with RN #1. RN #1 stated that Resident #121 was one of several residents who had not received medications that were charted on the Medication Administration Record (MAR) as being given. RN #1 stated that the medication in Resident #121's case was Vimpat (6), a controlled substance. A review of the Controlled Substances Log for Resident #121 revealed that on 05/11/2019 and	F 842		

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F 842	Continued From page 16 05/14/2019, both at 9:00a.m., Vimpat was recorded as being removed from the stock, but both entries were struck through with a line in black ink. The line following each entry had the Current Count number remain the same. The entry for 05/14/2019 at 9:00a.m., had "error" written in the column labeled "wasted". Nothing was written in the "wasted" column for the struck out entry on 05/11/2019. A review of Resident #121's MAR revealed that on both 05/11/2019 and 05/14/2019, Vimpat was documented as given at 9:00a.m. On 05/11/2019, Licensed Practical Nurse (LPN) #3 made the documented entry. The 05/14/2019 entry was documented as administered by LPN #4. On 05/30/2019 at 8:58a.m., an interview was conducted with LPN #3 regarding the discrepancy between the Controlled Substances log for Resident #121 showing a struck-out entry, and the medication administration record documenting the dose as given. LPN #3 stated that a crossed out line indicates an error. When asked what the error regarding the Vimpat was, LPN #3 stated, "I wrote it on the wrong resident's card". LPN #3 conformed that she had withdrawn a dose of Vimpat, but not for Resident #121, she stated that was correct. When shown the MAR, LPN #3 was asked what the initials on the 05/11/2019 9:00a.m., Vimpat entry meant. LPN #3 replied, "It says I administered it." When asked if Resident #121 actually received the Vimpat, LPN #3 stated "I don't remember whether he got it or not. I really don't know." On 05/30/2019 at 9:05a.m., an interview was conducted with LPN #4 regarding the discrepancy between the Controlled Substances log for Resident #121 showing a struck-out entry, and	F 842		

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F 842	Continued From page 17	F 842		

the medication administration record documenting the dose as given. When asked about the struck-out line in the Controlled Substances Log, LPN #4 stated, "That means I signed it out in error". When asked if the Current Count remaining the same meant that a dose was not pulled, LPN #4 replied "Yes". When asked why the Vimpat was marked as given on the MAR if the Controlled Substances Log indicates a dose was not pulled, LPN #4 stated; "Probably because I didn't pull it, but I clicked it off as given."

The facility staff indicated that their Nursing Standard was "Lippincott". The following is found in "Lippincott Nursing Procedures 6th Edition", page 230: "Documentation is the process of preparing a complete record of a patient ' s care and is a vital tool for communication among health care team members. Accurate, detailed charting shows the extent and quality of the care that nurses provide the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors."

ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) were informed of the findings at the End of Day meeting on 05/30/2019. No further documentation was provided.

6. Lacosamide is a controlled substance. Lacosamide is used in combination with other medications to control certain types of seizures. Lacosamide is in a class of medications called anticonvulsants. It works by decreasing abnormal electrical activity in the brain. -

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F 842	Continued From page 18 https://medlineplus.gov/druginfo/meds/a609028.html 3. The facility staff failed to document Resident #103's activities of daily living (ADL) assistance to include bed mobility, dressing, locomotion off unit, locomotion on unit, personal hygiene and transferring after it was provided on 5/25/19, 3 p.m. to 11 p.m. shift. Resident #103 was admitted to the facility on 8/31/18. Resident #103's diagnoses included but were not limited to: high blood pressure, diabetes mellitus type 2 and dementia. Resident #103's most recent MDS (minimal data set), a quarterly assessment with an ARD (assessment reference date) of 3/15/19, coded the resident's cognition as moderately impaired. . In addition, the Minimum Data set (MDS) coded Resident #103 as requiring existence assistance of one staff member with activities of daily living and supervision of one staff member with eating. Review of Resident #103's comprehensive care plan dated 3/1/19 documented, "Provide incontinent care with each episode and Provide assistance with activities of daily living as needed." Review of Resident #103's May 2019 activities of daily living (ADL) flowsheet revealed activities of daily living to include bed mobility, dressing, locomotion off unit, locomotion on unit, personal hygiene and transferring was not documented as completed on 5/25/19, 3 p.m. to 11 p.m. shift. On 5/29/19 at 9:30 a.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked about the process staff follows for documenting the resident's activities of	F 842		

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F 842	Continued From page 19 daily living. CNA #1 stated, "You document after you have finished providing assistance." CNA #1 was asked if he provided care to Resident #103 on 5/25/19, 3 p.m. to 11 p.m. shift. CNA #1 stated, "Yes, I did provide care to my resident but I forgot to document it". On 5/29/19 at 10 5:30 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional clinical coordinator) was made aware of the above concern. No information was presented prior to exit.	F 842		