STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING ______ B. WING ______	C 03/29/2017

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LOUDOUN NURSING AND REHAB CNTR	**235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176**

(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 abbreviated survey was conducted 3/28/17 through 3/29/17. A complaint was investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 100 bed certified facility was 95 at the time of the survey,. The survey sample consisted of eight current Resident reviews (Residents #1 through #6 and #8 through #9) and one closed record review (Resident #7).	F 000		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a resident's dignity in the care of an indwelling catheter bag for one of nine residents in the survey sample, Resident #5. The facility staff failed to cover the urinary collection bag for Resident #5. The findings include: Resident #5 was admitted to the facility on 11/23/16 with diagnoses that included but were	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/01/2017

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

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not limited to: non traumatic subdural hemorrhage (bleeding in the brain). high blood pressure, atrial fibrillation (rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output (1)), seizures and neurogenic bladder (urinary bladder that functions abnormally because of a nervous system lesion (2)).

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/1/17, coded Resident #5 as being severely impaired to make cognitive daily decisions and as having unclear speech. Resident #5 was coded as requiring extensive assistance to being totally dependent on one or more staff members to complete her activities of daily living. In Section H - Bladder and Bowel, the resident was coded as having an indwelling catheter (a tube used to drain urine from the bladder (3)).

On 3/28/17 at 12:08 p.m. during the initial tour of the facility an observation was made of Resident #5. Resident #5 was in the bed, closest to the door. The resident was asleep and facing the opened door. A urinary collection bag was visible on the frame of the bed. There was urine visible in the collection bag. There was no cover over the bag.

Resident #5 was observed again on 3/28/17 at 1:25 p.m. in the same position. The urinary collection bag was visible on the frame of the bed without a privacy covering.

Resident #5 was again observed on 3/28/17 at 2:25 p.m. The resident was now turned and

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facing the window. The urine collection bag was not visible from the door. It was located on the frame of the bed on the window side of the bed. There was no cover observed on the urine collection bag.

The physician order dated, 12/29/16, documented, "Cover Catheter Bag every shift; Special Instructions: Cover catheter bag with privacy bag."

The TAR (treatment administration record) for March 2017 documented, "Cover Catheter Bag every shift; Special Instructions: Cover catheter bag with privacy bag." The TAR documented the privacy cover as being in place on every shift for all days in March, including 3/28/17.

The comprehensive care plan dated, 12/1/16, with a reviewed date of 3/7/17, documented, "Problem: Requires use of indwelling catheter." The "Approach" documented, "Provide dignity cover for catheter when resident is out of room."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/29/17 at 11:50 a.m., regarding care of residents with Foley catheters. ASM #2 stated, "The bag should be stored lower than the bladder and has to be in a blue bag, that's a dignity issue."

On 3/29/17 at 12:52 p.m., an interview was conducted with CNA (certified nursing assistant) #1, the CNA who cared for the resident on 3/28/17 at the time of the above observations. When CNA #1 was asked if a resident with a Foley (indwelling catheter), required any special care for the urine collection bag. CNA #1 stated,

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"I have a resident who I have to turn every two hours. Each time I turn her from side to side I move the bag to the other side and below the level of the bladder." When asked if she took care of Resident #5 on 3/28/17 during the day shift, CNA #1 acknowledged that she had. When asked if the urine collection bag required any special care, CNA #1 stated, "It should be covered." The above observations were shared with CNA #1. CNA #1 stated, "When I was giving her care, sometimes the catheter bags leak and the blue bag was dirty and wet. I took it off. I then went to take residents to lunch. I forgot to put it back on."

An interview was conducted with RN (registered nurse) #5 on 3/29/17 at 12:58 p.m. When asked if there are any special instructions for a residents Foley catheter urine collection bag, RN #5 stated, "It should be stored in a blue bag at all times." When asked why it should be stored in a blue bag, RN #5 stated, "It's for privacy and dignity."

The facility policy, "Catheters - Care of Indwelling," documented in part, "C. Method...9. All Indwelling Catheter bags will be placed in a dignity bag."

The administrator, assistant administrator and ASM #2 were made aware of the above concern on 3/29/17 at 2:58 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 400.

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(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 108.

F 309 SS=D PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING F 309

CFR(s): 483.24, 483.25(k)(l)

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards

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of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the physician orders for one of nine residents in the survey sample, Resident #5.

The facility staff failed to follow the physician's order to cover the catheter bag for Resident #5.

The findings include:

Resident #5 was admitted to the facility on 11/23/16 with diagnoses that included but were not limited to: non traumatic subdural hemorrhage (bleeding in the brain). high blood pressure, atrial fibrillation (rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output (1)), seizures and neurogenic bladder (urinary bladder that functions abnormally because of a nervous system lesion (2)).

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/1/17, coded Resident #5 as being severely impaired to make cognitive daily decisions and as having unclear speech. Resident #5 was coded as requiring extensive assistance to being totally dependent on one or more staff members to complete her activities of daily living. In Section H - Bladder and Bowel, the resident was coded as having an indwelling catheter (a tube used to

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drain urine from the bladder (3)).

On 3/28/17 at 12:08 p.m. during the initial tour of the facility an observation was made of Resident #5. Resident #5 was in the bed, closest to the door. The resident was asleep and facing the opened door. A urinary collection bag was visible on the frame of the bed. There was urine visible in the collection bag. There was no cover over the bag.

Resident #5 was observed again on 3/28/17 at 1:25 p.m. in the same position. The urinary collection bag was visible on the frame of the bed without a privacy covering.

Resident #5 was again observed on 3/28/17 at 2:25 p.m. The resident was now turned and facing the window. The urine collection bag was not visible from the door. It was located on the frame of the bed on the window side of the bed. There was no cover observed on the urine collection bag.

The physician order dated, 12/29/16, documented, "Cover Catheter Bag every shift; Special Instructions: Cover catheter bag with privacy bag."

The TAR (treatment administration record) for March 2017 documented, "Cover Catheter Bag every shift; Special Instructions: Cover catheter bag with privacy bag." The TAR documented the privacy cover as being in place on every shift for all days in March, including 3/28/17.

The comprehensive care plan dated, 12/1/16, with a reviewed date of 3/7/17, documented, "Problem: Requires use of indwelling catheter."

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The "Approach" documented, "Provide dignity cover for catheter when resident is out of room."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/29/17 at 11:50 a.m., regarding care of residents with Foley catheters. ASM #2 stated, "The bag should be stored lower than the bladder and has to be in a blue bag, that's a dignity issue."

On 3/29/17 at 12:52 p.m., an interview was conducted with CNA (certified nursing assistant) #1, the CNA who cared for the resident on 3/28/17 at the time of the above observations. When CNA #1 was asked if a resident with a Foley (indwelling catheter), required any special care for the urine collection bag. CNA #1 stated, "I have a resident who I have to turn every two hours. Each time I turn her from side to side I move the bag to the other side and below the level of the bladder." When asked if she took care of Resident #5 on 3/28/17 during the day shift, CNA #1 acknowledged that she had. When asked if the urine collection bag required any special care, CNA #1 stated, "It should be covered." The above observations were shared with CNA #1. CNA #1 stated, "When I was giving her care, sometimes the catheter bags leak and the blue bag was dirty and wet. I took it off. I then went to take residents to lunch. I forgot to put it back on."

An interview was conducted with RN (registered nurse) #5 on 3/29/17 at 12:58 p.m. When asked if there are any special instructions for a residents Foley catheter urine collection bag, RN #5 stated, "It should be stored in a blue bag at all times." When asked why it should be stored in a blue bag, RN #5 stated, "It's for privacy and dignity."

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The administrator, assistant administrator and ASM #2 were made aware of the above concern on 3/29/17 at 2:58 p.m. A copy of a policy for following physician's orders was requested and was not provided.

No further information was provided prior to exit.

F 323 SS=G — FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES — F 323
CFR(s): 483.25(d)(1)(2)(n)(1)-(3)

(d) Accidents.
The facility must ensure that -

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

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

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

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

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

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced

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F 323	Continued From page 9 by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to ensure adequate supervision and consistent implementation of a physician ordered assistive device to prevent an avoidable accidents for one of nine residents in the survey sample, Resident #1. The facility staff failed to ensure Resident #1's physician ordered tab alarm (an assistive safety device used to reduce falls) was re-applied in a timely manner. Resident #1, who was assessed as at risk for falls, was found without the physician ordered tab alarm in place and the facility staff left Resident #1 unsupervised without a tab alarm. Resident #1 subsequently fell and sustained a fractured pelvis and left wrist. The findings include: Resident #1 was admitted to the facility on 2/1/17 and readmitted on 3/8/17 with diagnoses that included but were not limited to: stroke, falls, high blood pressure, urinary tract infection and dementia. The most recent minimum data set (MDS), a 14 day assessment, with an assessment reference date of 3/4/17 coded Resident #1 as having scored four out of 15 on the brief interview for mental status indicating the resident was severely impaired cognitively to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. Resident #1's admission MDS assessment dated 2/8/17, coded the resident in section J1700, "Fall	F 323	Past noncompliance: no plan of correction required.	

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F 323	Continued From page 10 History on Admission/Entry or Reentry" as follows: "A. Did the resident have a fall any time in the last month prior to admission/entry or reentry?" A "9" was documented indicating the staff was unable to determine if a fall had occurred. Review of the physician's orders dated and signed on 2/1/17 documented, "ALARM* BED TAB (CHECK PLACEMENT AND FUNCTION).... Every Shift...TX (treatment) -- Every Shift SPECIAL INSTRUCTIONS: FOR PATIENT SAFETY AWARENESS AND TO ALERT STAFF OF ATTEMPTS TO AMBULATE UNASSISTED." Review of the physician's history and physical dated 2/1/17 documented, "She is increasingly confused and a fall risk. She is currently at the nurse station monitored one-to-one by nurses...She has a history of Alzheimer's-type dementia with worsening of cognitive status after the stroke and UTI (urinary tract infection)." Review of the care plan initiated on 2/13/17 and revised on 2/19/17 documented, "PROBLEM. Resident has risk for falls and/or history of falls related to, Unsteady/Impaired Gait, Short Term Memory Loss, Requires Staff Assistance for Transfers, Agitation/Unsafe Behavior. APPROACH. Apply personal alarm -- bed/chair Tab (alarm)." Review of the February 2017 treatment administration record (TAR) documented, "ALARM* BED TAB (CHECK PLACEMENT AND FUNCTION)....Every Shift... TX (treatment) -- Every Shift SPECIAL INSTRUCTIONS: FOR PATIENT SAFETY AWARENESS AND TO ALERT STAFF OF ATTEMPTS TO AMBULATE	F 323		

F 323 Continued From page 11 F 323

UNASSISTED." It was documented that the bed alarm had been checked each shift from 2/1/17 to 2/15/17.

Review of the fall risk assessment dated 2/1/17 documented that Resident #1's fall risk was 27. There was a box at the bottom of the page that documented, "TOTAL SCORE. To be completed on admission and quarterly. If score is over 12, interventions will be put into place and the Care Plan revised."

Review of the admission assessment dated 2/1/17 at 6:40 p.m. documented, "COGNITIVE ABILITY. Confused."

Review of the nurse's note dated 2/1/17 at 6:40 p.m. documented in part, "87 year old female arrived via stretcher from (name of hospital). Diagnosis of CVA (stroke), (left) sided weakness...Other diagnoses include -- ...Dementia...Tab alarm applied....Found by CNA (certified nursing assistant) climbing out of bed. Alarm went off. Transferred to recliner. Brought to nurses station."

Review of the nurse's notes dated 2/5/17 at 3:30 a.m. "Attempted to get out of bed x1. Patient was toileted and put back to bed. Tab Alarm in place. Will continue to monitor." Review of the nurse's note dated 2/5/17 at 9:30 a.m. documented, "Trying to get out of the bed x3 (three times) w/o (without) help. Safety measures in place." At 2:00 p.m. it was documented, "Attempt OOB (out of bed) x1, assisted to BSC (bedside commode)...Safety maintained and continue to monitor."

Review of the nurse's note dated 2/15/17 at 3:20

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a.m. documented, "Patient slept well....Will continue to monitor." At 4:00 a.m. it was documented, "This Nurse was called to Patient's room. Patient was on the floor beside the bed lying on (left) side of her body. Assessment was done and Patient c/o (complained of) pain to (left) arm, (left) hip and her back....Sent to Emergency room for evaluation...When this Nurse called Son to make him aware he stated, "She has fallen a lot of times and only had a bruised head."

Review of the emergency room records dated 2/15/17 at 7:28 a.m. documented, "(Name of Resident #1) is an 88 y.o. (year old) female Presents after fall. PT (patient) states she fell, does not know why, complains of left wrist and hip pain. She is at the rehab (rehabilitation), hx (history) of dementia and stroke, is only supposed to be up with assistance and per facility was out of bed....Per rehab, (name of resident) is a two-person assist for ambulation and does not walk on her own or with the assistance of a walker." Past Medical History:...History of falling."

Review of the left hip x-ray results dated 2/15/17 at 5:53 a.m. documented, "Impression. Acute fracture of the left pubic tubercle (1) with extension to the left superior pubic ramus (2), moderate comminution and mild displacement. Possible acute nondisplaced fracture of the left pubic ramus. Acute fracture of the left sacral wing (3) with mild displacement.

Review of the left wrist x-ray result dated 2/15/17 at 7:25 a.m. documented, "Acute fracture of the metaphysis (4) of the distal radius (arm bone) which now demonstrates moderated displacement and volar angulation (5)."

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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
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An interview was conducted on 3/29/17 at 9:50 a.m. with RN (registered nurse) #1, the unit manager where the resident resided at the time of the fall. When asked what she remembered about the fall, RN #1 stated, "The night time supervisor advised me of the fall at 4:40 in the morning. The resident was sent to the ER (emergency room) and I knew it (the x-ray) was positive for a left wrist fracture." When asked what safety precautions had been in place at the time of the fall, RN #1 stated, "A tab alarm." When asked if the alarm had been functioning at the time, RN #1 stated, "The staff told me it was working. I asked if they had taken her to the bathroom, (name of LPN [licensed practical nurse] # 1) said yes that she and an aide had taken the resident to the bathroom at 2:00 a.m. It took about thirty minutes and they put her back to bed." When asked what the resident's cognitive status was, RN #1 stated, "She was alert and oriented to herself only. She had a history of falls prior to admission which is why we had the tab alarm on her." When asked if the resident had attempted to get out of bed on her own before, RN #1 stated, "I think she had a couple times. When she tried to get out of bed she was too weak and couldn't get up."

The fall investigation for Resident #1's fall was requested on 3/29/17 at 10:00 a.m. from ASM #2, the director of nursing.

A telephone interview was conducted on 3/29/17 at 10:05 a.m. with LPN #1, the nurse caring for Resident #1 at the time of the fall. When asked what she remembered about that night, LPN #1 stated, "We had taken her to the bathroom around 2:00 a.m. and put her back to bed. We were looking for the tab alarm and couldn't find it.

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It was a really busy night so I told the aide to go answer the lights and I said 'I'll go get one.' When I left the room I was stopped by one of the residents by the time I got back (to the resident's room) she had fallen." LPN #1 was asked why it took from 2:00 a.m. to 4:00 a.m. to get the tab alarm for the resident. LPN #1 stated, "No, it was only 40 minutes and she hadn't tried getting up in a while."

Review of Resident #1's fall accident report documented, "Describe the Incident. This nurse was called to Patient's room. Patient was on the floor beside the bed. Lying on (left) side of her body. Assessment was done and Patient c/o (complained of) pain to (left) arm, (left hip) and her back. CIRCLE THE SAFETY DEVICES IN PLACE:" Bed tabs and chair tabs were circled. "Falls Investigation Review. History of Falls?" Yes was circled. "Tabs/Alarm in Use?" Yes was circled. (*note at the time of the fall there was no tab alarm in place).

A meeting was conducted on 3/29/17 at 11:10 a.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3 the assistant administrator. ASM #1 presented a letter dated 3/27/17 and addressed to the appropriate reporting agency outlining the resident's fall on 2/15/17. ASM #1 stated, "We were going to mail this yesterday and then you came in. Because we did not know why you were here we didn't give this to you." Review of the letter documented in part, "Meetings with the staff occurred on 2/16/2017 to further investigate the fall. (Name of resident) demonstrated as very weak, requiring 2 assist to ambulate and was not doing well in therapy due to weakness. (Name of resident) did not ambulate or use walker alone. A

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F 323	Continued From page 15 tabs monitor was ordered for (name of resident). The tabs alarm was documented in the MAR (medication administration record)/TAR (treatment administration record) as being in place on the evening shift and for the 11 - 7 (11:00 p.m. to 7:00 a.m.) shift of the fall. The C.N.A.(certified nursing assistant) caring for (Resident #1) states she does her vital signs on rounding at the first of the shift and she knows it was attached. She required max (maximum) assist of two to be ambulated to the bathroom. After returning the resident/patient from the restroom to her bed, the tabs alarm could not be located and a search of the room did not locate the device. C.N.A. explained that resident call lights were going off on the unit, so the Charge Nurse asked her to go ahead and answer the lights and the charge nurse would just get a new device for (name of resident). (Name of resident) had demonstrated in the past, behavior capability of using the call light; consequently the nursing call bell was left with the patient to call for help. The Charge Nurse was delaying in returning with the tabs device as she was called by another resident for assistance." ASM #2 stated she had developed a plan of correction. ASM #2 was asked the process she followed to investigate a fall, ASM #2 stated, "We do a safety investigation with our falls and we meet every week with the interdisciplinary team for all falls. The unit manager goes down and talks to the staff." When asked if there were staff statements regarding Resident #1's fall, ASM #2 stated, "We only do those if we suspect abuse. I started an investigation after APS (adult protective services) came in (about the incident)." APS had been in the facility on 3/16/17. When asked if that was when they discovered that the resident did not have a tab alarm on at the time of the fall, ASM	F 323		

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#2 stated it was. ASM #2 stated she had given an in-service on safety devices to the night shift on the unit Resident #1 resided. A request was made for the plan correction at this time.

An interview was conducted on 3/29/17 at 12:05 p.m. with RN #1, the unit manager. When asked why residents have tab alarms, RN #1 stated, "To raise awareness of them trying to get out of bed." When asked what should occur when a physician orders a tab alarm, RN #1 stated, "That they have a tab alarm on at all times." When informed of the telephone interview with LPN #1, RN #1 stated she had not been aware that the resident was without the tab alarm. RN #1 was then asked if 40 minutes to replace a tab alarm was a long time. RN #1 stated it was.

An interview was conducted on 3/29/17 at 12:35 p.m. with CNA #1 and CNA #2. When asked what they do for a resident with a tab alarm, CNA #1 stated, "I have people who climb out of bed. We check their alarms. If it alarms I take off running." When asked if they had ever had a resident with a tab alarm fall, CNA #1 and #2 replied, "No." When asked what they would do if a tab alarm needed to be replaced, CNA #1 stated, "I'd keep them (the resident) with me until I get the alarm. We don't want them to fall."

An interview was conducted on 3/29/17 at 1:00 p.m. with RN #5. When asked why a resident had a tab alarm, RN #5 stated, "For safety for residents with a high risk for falling." When asked the process for checking the alarm, RN #5 stated, "First when we do our rounds we check them."

An interview was conducted on 3/29/17 at 1:05 p.m. with CNA #6. "When asked what process

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staff follows if a tab alarm needs to be replaced, CNA #6 stated, "I would tell the supervisor." When asked what he would do with the resident while he waited for the alarm, CNA #6 stated, "I'd probably take them with me to make sure they're safe."

An interview was conducted on 3/29/17 at 1:50 p.m. with ASM #2, the director of nursing. When asked about the process staff should follow if a physician ordered tab alarm was missing, ASM #2 stated, "When two people are involved, one person should go out and get the tab alarm and the other one stays with the resident. The tab alarm doesn't prevent falls." When asked if the facility had had a resident fall while using a tab alarm, ASM #2 stated, "Yes, we have had falls. The staff runs (when they hear them). We use them as an alert system."

An interview was conducted on 3/29/17 at 2:58 p.m. with CNA #4, the CNA who had cared for Resident #1 the night she fell. When asked the process staff follow when a resident had a tab alarm, CNA #4 stated, "First of all I ensure that everyone is in their bed and then I check to make sure the tab alarms are there." When asked if Resident #1 had a tab alarm on that night, CNA #4 stated, "When I did her vital signs it was on. I have to touch her and I could see it." When asked about that night, CNA #4 stated, "That night for some reason she was trying to get out of bed." When asked how she knew that, CNA #4 stated, "The roommate called. When asked if the alarm had gone off, CNA #4 stated, "No, because her legs were over the side of the bed but her body was on the bed. She said she wanted to go to the bathroom. I knew she couldn't ambulate because of her stroke. We took her to the bathroom and

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took her back to bed and started looking for the tab alarm. The nurse told me we need to put on a new tab alarm and then there were more than one call light on. By the time I got back to her it wasn't more than 15 minutes." When asked why she didn't stay with the resident while the nurse got the alarm, CNA #4 stated, "Because we had multiple lights going on and this is a person who never gets out of bed."

An interview was conducted 3/29/17 at 3:10 p.m. with CNA #5, an aide who cared for the resident. When asked if the resident tried to get out of bed, CNA #5 stated, "Sometimes we would see her with her legs over the side of the bed. A couple times the tab alarm was ringing and she was sitting on the side of the bed." When asked if she usually had enough time to get to the resident when they hear the alarm and before they fell, CNA #5 stated, "Yes ma'am. When we're at the nurse's station as soon as an alarm goes off everybody goes running."

On 3/29/17 at 3:25 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant administrator were made aware of the concern for harm.

On 3/29/17 at 4:45 p.m. ASM #2 and ASM #3 provided a copy of the plan of correction.

"PLAN OF CORRECTION:
1. Corrective Actions/New Interventions in place: Upon re-admission to this facility on 2/19/17, the resident was placed in a (name of company) low bed with mats next to each side of the bed. A tabs alarm for both bed and chair and a mattress alarm were in place for this Resident.
2. Other Potential Residents: All resident who are

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F 323	Continued From page 19 a fall risk with safety devices are potentially affected however, no non-compliance was noted. 3. Systemic Changes: Inservice meetings with Nursing Staff on the first floor unit were conducted as follows: a. Direction of Nursing held inservice on 2/16/16 at 6:30 AM with 11 - 7 shift to review policy and procedures in regard to falls, the Star Alert Program and safety devices (see attached attendance sheet). b. The RN Unit Manger held Nursing Huddle/Unit Meetings on 2/16/17 for both 7-3 (7:00 a.m. to 3:00 p.m.) shift and 3-11 (3:00 p.m. to 11:00 p.m.) shift. Content reviewed included Tab Alarms, Falls and Safety Devices. The incident/accident for Resident (resident's initials) was reviewed with the Staff (see attendance sheet). 4. Monitoring: A bi-monthly Quality Audit of all Safety Devices on first floor was conducted by the RN Unit Manager on 3/8/17 and 3/27/17 (see attached audits). The RN Unit Manager audited for the presence of a Physician order for a Safety Device and verified visually that the safety device was present on the resident (s) No non-compliance was found. This audit will continue bi-monthly with a summary report submitted to the Performance Improvement Committee quarterly. The Performance Improvement Committee will review a summary pf (sic) the audits and provide additional recommendations, including the frequency of continued audits." The allegation of compliance date was 3/27/17. Review of the facility's policy on falls and safety devices did not evidence documentation pertinent to this incident. No further information was provided prior to exit.	F 323		

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F 323	Continued From page 20 (1) Pubic tubercle -- a nodule or small eminence, especially one on a bone, for attachment of a tendon; see also tuber and tuberosity. Called also tuberculum. adj., adj tuber´cular, tuber´culate. This information was obtained from: http://medical-dictionary.thefreedictionary.com/Pubic+tubercle (2) Pubic ramus -- Either of the two barlike processes of the pubic bone that extend laterally and posteriorly from the pubic symphysis. This information was obtained from: http://medical-dictionary.thefreedictionary.com/pubic+ramus (3) Sacral wing -- A triangular bone made up of five fused vertebrae and forming the posterior section of the pelvis. This information was obtained from: http://www.thefreedictionary.com/sacrum (1) Metaphysis -- The wider part at the end of the shaft of a long bone, adjacent to the epiphyseal disk. This information was obtained from: http://medical-dictionary.thefreedictionary.com/metaphysis (2) Volar -- pertaining to the sole or palm: indicating the flexor surface of the forearm, wrist or hand. This information was obtained from: http://medical-dictionary.thefreedictionary.com/volar+angulation COMPLAINT DEFICIENCY	F 323		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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CFR(s): 483.70(i)(1)(5)

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

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident’s assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician’s, nurse’s, and other licensed professional’s progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain a complete and

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accurate clinical record for one of nine residents in the survey sample, Resident #1.

The facility staff failed to document Resident #1's blood pressures as ordered by the physician.

The findings include:

Resident #1 was admitted to the facility on 2/1/17 and readmitted on 3/8/17 with diagnoses that included but were not limited to: stroke, falls, high blood pressure, urinary tract infection and dementia. The most recent minimum data set, a 14 day assessment, with an assessment reference date of 3/4/17 coded the resident as having a four out of 15 on the brief interview for mental status indicating the resident was severely impaired cognitively to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the care plan initiated on 2/13/17 and revised on 2/17/17 documented, "Problem/Concern. Resident is at risk for alteration in cardiac output related to: hypertension (high blood pressure). Approach. Assess vital signs per protocol/order...Administer medication/follow parameters per order: see MAR (medication administration record)."

Review of the physician's orders dated and signed on 2/18/17 documented, "Toprol (1)...XL (extended release) Oral Tablet Extended Release 24 Hour 25 MG (milligrams) 3 Tablet PO (by mouth)...BP (blood pressure) PARAMETERS HOLD BP MEDICATION AND NOTIFY MD (medical doctor) IF SBP (systolic blood pressure) IS LESS THAN 110 OR AS OTHERWISE INDICATED WITH SPECIFIC MEDICATION."

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Review of the March 2017 MAR documented, "Toprol (1)...XL (extended release) Oral Tablet Extended Release 24 Hour 25 MG (milligrams) 3 Tablet PO (by mouth)...BP (blood pressure) PARAMETERS HOLD BP MEDICATION AND NOTIFY MD (medical doctor) IF SBP (systolic blood pressure) IS LESS THAN 110 OR AS OTHERWISE INDICATED WITH SPECIFIC MEDICATION." The medication was documented as being administered each day. Further review of the MAR did not evidence documentation of the resident's blood pressures.

Review of Resident #1's nurse's notes did not evidence documentation of the blood pressure.

An interview was conducted on 3/29/17 at 9:27 a.m. with LPN (licensed practical nurse) #2, the nurse caring for Resident #1. When asked about the process staff follows for physician ordered blood pressure parameters on a medication, LPN #2 stated, "If it's (blood pressure) low it means I'm not going to give it (medication) and I put it (holding the medication) in the chart and let the next shift know. I also have to call the doctor." When asked how staff would know what the resident's blood pressure was prior to giving the medication, LPN #2 stated, "We only do it (document the blood pressure) if it's outside of the parameters." When asked how staff could be sure that the blood pressure had been taken, LPN #2 stated, "We should do it (blood pressure), it's our job." When asked if she had checked Resident #1's blood pressure prior to giving the Toprol, LPN #2 stated, "Yes, it was 133/74."

An interview was conducted on 3/29/17 at 9:40 a.m. with RN (registered nurse) #2, the unit

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F 514	Continued From page 24 manager. When asked about the process staff follows for physician ordered blood pressure parameters on a medication, RN #2 stated, "We would hold it per the parameters." RN #2 was asked to review Resident #1's MAR and Toprol XL for March 2017. When asked if she would expect to see blood pressures documented, RN #2 stated, "Yes. If you hover here (indicating the Toprol XL) it brings up a calendar and staff can document the blood pressure there." When RN #2 brought up the calendar it was blank, RN #2 stated, "I'll fix it right now and make sure they're all doing it." An interview was conducted on 3/29/17 at 11:10 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked if staff were to document blood pressures when a physician ordered blood pressure parameters on a medication, ASM #2 stated, "In (name of software) if you hover over it (name of medication) it'll bring up the calendar and you'll see the vital signs. When asked if she would expect to see blood pressures documented for Resident #1, ASM #2 stated, "If it's ordered it should be documented." ASM #2 was made aware of the findings at that time. Review of the facility's policy titled, "CHARTING -- GUIDELINES AND REQUIRED NURSING DOCUMENTATION" documented, "The completed medical record contains an accurate and functional representation of the actual experiences of the resident in the facility. Information in the record is sufficient to demonstrate that the facility nursing staff, family and physician know the status of the resident. The medical record contains sufficient documentation documenting care provided and	F 514		

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LOUDOUN NURSING AND REHAB CNTR	**235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 25 the results of care provided." No further information was provided prior to exit. (1) TOPROL-XL is indicated for the treatment of hypertension, to lower blood pressure. Lowering blood pressure lowers the risk of fatal and non-fatal cardiovascular events, primarily strokes and myocardial infarctions. These benefits have been seen in controlled trials of antihypertensive drugs from a wide variety of pharmacologic classes including metoprolol. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4a5762c6-d7a2-4e4c-10b7-8832b36fa5f4	F 514		