FOIA Data Base - The Law Office of Jeffrey Downey

Serving clients in Virginia, Maryland and Washington D.C.

If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation

Phone: 703-564-7318; email: jdowney@jeffdowney.com;

Visit http://www.jeffdowney.com

Cherrydale Health and Rehabilitation Center

3710 Lee Hwy
Arlington Virginia
Phone 703-243-7640

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:

Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The Virginia Department of Health inspects nursing homes including Cherrydale. Every year they do annual inspections and complaint surveys which should be public record. You can write to the Department of Health directly to request statements of deficiencies at Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Henrico, Virginia, 23233. A typical FOIA request will take about two weeks and will cost anywhere from $40 to $120 dollars

Having already researched Cherrydale and obtained FOIA responses, I am posting their statements of deficiencies here, in a searchable format. I am interested in any additional information you may have on this facility. Please call me with any questions about this or any other facility you may be interested in researching.

Facility Characteristics:

- Skilled nursing facility with 240 beds offering skilled care rehab for stroke and cardiac patients. Referral sources include Arlington Hospital
- Operated by the chain, Medical Facilities of America Inc.
- Website at cherrydatehealthrehab.com
- Fiscal year balance sheets showed gross patient revenues in 2016 of $29,025,098 with expenses totaling $17,942.466.
- As of 2018 Cherrydale was evaluated as a one-star facility (much below average) on Medicare.gov

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Disclaimer: The following information comes from a Freedom of Information Act (FOIA) issued to the Virginia Department of Health, Office of licensure and certification. Not all surveys have been copied to this website. In addition, the online compliance history includes information regarding adverse actions that may be the subject of a pending appeal or plans of correction. An adverse action is not final until a provider has exhausted or waived all due process rights. Not all the information contained herein is necessarily current and errors may have occurred in the conversion of this document from PDF to a searchable word document. Anyone considering admission to a nursing facility should review the most recent survey results and visit the facility to make their own observations about the quality of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED C
	495121		08/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYDALE HEALTH AND REHABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207

(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	F 000		
	An unannounced Medicare/Medicaid standard survey was conducted 8/1/17 through 8/2/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 180 certified bed facility was 175 at the time of the survey. The survey sample consisted of 24 current Resident reviews (Residents 1 through 24) and 3 closed record review (Residents 25 through 27).			
F 167 SS=C	483.1O(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F 167		'8/18/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/11/2017

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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(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

(iv) The facility shall not make available identifying, information about complainants or residents.
This REQUIREMENT is not met as evidenced by:
Based on observation, group interview, and staff interview, the facility staff failed to ensure survey results were readily accessible. There was no notice posted of where the survey results were located, and the survey results book was kept in a drawer.

Findings include:

On 8/1/17 a group interview was conducted beginning at 2:00 p.m. with thirteen cognitive residents in attendance. The group was asked if they were aware that the survey results from the previous year were available for review. One resident was aware that the survey results notebook was kept in the lobby in a drawer. The other twelve residents were unaware of the survey results book, or where it was located.

On 8/1/17 at 3:20 p.m. this surveyor went to the lobby to look for the survey results book. There were no signs posted to indicate where the book was. The receptionist, identified as other staff (OS)# 2 was asked where the survey results book was kept. bs # 2 stated "Oh, it's over there in that chest under the big mirror in the top drawer." This surveyor went to the chest and opened the top drawer; there was a plain, white binder in the drawer. The binder had no writing to indicate that survey results were contained in the binder. This surveyor then asked OS # 2 about

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The statements made in the following plan of correction are not an admission to ' and do not constitute an agreement with the alleged deficiencies nor the reported , conversations and other information cited , in support of the alleged deficiencies. The\ **facility sets forth the following plan of** correction to remain in compliance with all I federal and state regulations. The facility ; has taken or will take the actions set forth ! in the plan of correction. The following plan of correction constitutes the facility! s / allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.

1. Signage to alert residents where the survey results are placed in the Lobby area of the Center was posted on 8/2/2017 for easy accessibility.
2. The availability and accessibility of the survey results to be discussed during the next resident council meeting scheduled for 8/17/2017
3. Re-education of facility staff and patients completed to include:
a. Ensuring patient accessibility to the survey result
b. Monitoring the survey result accessibility to ensure the presence of posted notice alerting the residents/public

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F 167	Continued From page 2 the lack of indication on the binder, and the lack of signage to alert residents, visitors, and families of the location of the book. OS # 2 stated "If someone asks me about it, I tell them where it is. There's not been a notice up as far as I know." This surveyor then asked the receptionist how anyone was to know to ask for the location of the book if they were unaware that a survey result book was available. OS # 2 just looked at this surveyor and did not answer. On 8/2/17 during a meeting with facility staff beginning at 10:55 a.m. the administrator, DON (director of nursing), and nurse consultant were made aware of the above findings. The administrator stated "We can put up a notice and put the book out; that's no problem." No further information was provided prior to the exit conference.	F 167	where to find the result c. Patient education on where and how to access the survey result placed on the Lobby 4. The Administrator/DON/Designee will : audit weekly x2 weeks, monthly x2 months, and quarterly x1 the availability of posted notice alerting the residents/public , where the survey result is located. Any deviation noted will be forwarded to the QA committee for further review and resolution. 5. Date of compliance is August 18, **2017**	
F 252 SS=D	483.10(e}(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.1O(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or	F 252		,8/18/17

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her personal belongings to the extent possible.

(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.

(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical ' record review, the facility staff failed to ensure a safe, clean, homelike environment for one of 27 residents in the survey sample. Resident #2's room had broken base board molding, a wall rail with a missing end cap, a dirty box fan in use and i a slow draining sink.

The findings include:

Resident #2 was admitted to the facility on 7/6/12 with a re-admission on 5/31/16. Diagnoses for Resident #2 included Parkinson's disease, dysphagia with a gastric tube, high blood pressure and respiratory failure. The minimum data set (MOS) dated 5/15/17 assessed Resident #2 with severely impaired cognitive skills.

On 8/1/17 at 9:15 a.m. Resident #2 was observed in bed. A box fan positioned on the wall unit shelf was running. The grate on the front of the fan was covered with gray lint particles. The lint was attached to the plastic grate with strands being blown by air movement from the running fan. On 8/1/17 at 10:50 a.m. accompanied by the licensed practical nurse (LPN #2) caring for Resident #2, the fan with the dirty grate was inspected. LPN

F 252

1. Resident #2 broken baseboard molding fixed on 8/2/17. Wall rail with missing end cap fixed on 8/2/17. Dirty box i fan replaced on 8/1/17. Slow draining sink i fixedon8/1/17.
2. Facility Director of Maintenance and : staff audited all rooms on 8/2/17 with any i area needing repair addressed
3. Re-education of facility in the following: areas:
a. Monitoring, assessing, and notifying of the Maintenance Department of any compromised baseboard molding, sink, wall rail, and dirty fan.
b. Daily patients! 1 environmental rooms round and protocols for reporting maintenance related issues to the Maintenance Department
c. Maintenance department routine environmental round for possible proactive maintenance.
4. The Administrator/Director of maintenance will monitor and audit 10% of all patient rooms weekly x3 months to ensure that there are no damaged baseboard molding, broken wall rails, dirty box fans, and slow draining sink. Any

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#2 was interviewed at this time about the dirty fan. LPN #2 stated the fan was used because the room was "stuffy." LPN #2 stated she was not sure who was supposed to keep the fan clean.

On 8/2/17 at 9:00 a.m. LPN #2 was observed washing her hands in the sink in Resident #2's room. Water backed up in the sink during the hand washing. The faucet on the sink had no aerator. Resident #2's room was inspected further at this time. There was an unattached section (approximately 6 inches in length) of base board molding at the corner of the wall unit and the sink wall near the floor. The wall rail located approximately eight inches from the floor between the sink area and the corner of the wall unit was missing an end cap.

On 8/2/17 at 9:50 a.m. LPN #2 was interviewed about Resident #2's room items needing repair. LPN #2 stated work orders were supposed to be sent to maintenance for any items needing repair.

These findings were reviewed with the administrator and director of nursing during a meeting on 8/2/17 at 10:50 a.m.

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observed anomaly will be forwarded to the: QA committee for review and recommendation.
5. Date of compliance is August 18, **2017**

F 278 483.20(g)-(j) ASSESSMENT
SS=D **ACCURACY/COORDINATION/CERTIFIED**

F278 **8/18/17**

(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

(h) Coordination
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

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(i) Certification
(1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for Falsification
(1) Under Medicare and Medicaid, an individual who willfully and knowingly-

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, facility staff failed to ensure a complete and accurate MDS (minimum data set) for one of 27 residents in the survey sample, Resident #3.

Facility staff failed to code Resident #3 properly for the use of restraints on a Significant Change assessment with an ARD (assessment reference date) of 05/09/17 and a Quarterly assessment with an ARD of 06/08/17.

F 278

1. Resident #31 s MDS, Section P for Assessment Reference Date of 5/9/2017 and 6/8/17 was corrected on 8/1/2017 to reflect the patient use of a side rail.
2. An audit of Section P of the MDS for current residents using bed rails will be reviewed to ensure accurate coding. Any discrepancy will be rectified accordingly
3. Re-education of MDS registered nurses by the Data Analysis & Verification Specialist will be completed to include:
a. Accurate completion of Section P of

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Findings included:

Resident #3 was originally admitted to the facility on 05/07/13 and readmitted on 07/28/17 with diagnoses including, but not limited to: Congestive Heart Failure, Atrial Fibrillation, Diabetes, Chronic Obstructive Pulmonary Disease, Pneumonia, R spiratory Failure, Anxiety, Depression and Psychotic Disorder.

The most recent MOS was a quarterly assessment with an ARD of 06/08/17. Resident #3 was assessed as severely impaired in her cognitive status with a total cognitive score of zero out of 15.

On 08/01/17 at 10:30 a.m., Resident #3 was observed in her room, lying in a large, bariatric bed with full side rails in place bilaterally. At approximately 10:50 a.m. Resident #3's EMR (electronic medical record) was reviewed. During the EMR review Physical Restraint Evaluations dated 04/04/17 and 06/01/17 were noted. Both evaluations included documentation that stated: "A. Reason For Restraint...14. Comments: ...Bariatric bed has side rails that cannot be removed per manufacture's guidelines...C. Effectiveness of Restraint...Side rails do not affect resident in any adverse way. They help in bed mobility, turning, repositioning..." Review of Resident #3's care plan included a focus on the bariatric bed with full side rails, with appropriate goals and interventions noted.

MOS assessments dated 05/09/17 and 06/08/17 under Section P - Restraints included the following documentation: "P0100. Physical Restraints. Physical restraints are any manual or physical or mechanical device, material or

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the MOS with every ARD date for patient on restraints.
4. Data Analysis & Verification Specialist/Designee will review Section P of MDS assessment on patients with restraints weekly x1 month, and then monthly x3 to ensure accurate codding of the section. Any anomaly noted will be rectified accordingly. Facility will also forward the finding to the QA committee for further review and recommendation.
5. Date of compliance is August 18, 2017

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equipment attached to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Used in Bed. A. Bed rail 0. [zero] Not used..."

Per CMS's "RAI Version 3.0 Manual CH 3: MOS Items [P] Section P: Restraints Intent: The intent of this section is to record the frequency over the 7-day look-back period that the resident was restrained by any of the listed devices at any time during the day or night. Assessors will evaluate whether or not a device meets the definition of a physical restraint and code only the . devices that meet the definition in the appropriate . categories of Item P0100. DEFINITION PHYSICAL RESTRAINTS: Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP). Steps for Assessment: 356.

Considering the physical restraint definition as well as the clarifications listed below, observe the resident to determine the effect the restraint has on the resident's normal function. Do not focus on the type, intent, or reason behind its use. Coding Tips and Special Populations: Bed rails include any combination of partial or full rails (e.g., one-side half-rail, one-side full rail, two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom, etc.). Include in this category enclosed bed systems. Bed rails used as positioning devices. If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meet the definition of a physical restraint even though they

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may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A." (1)

On 08/02/17 at 8:45 a.m., RN #1 (registered nurse), MOS Coordinator was interviewed regarding Resident #3's restraint assessments included on MDS's dated 05/09/17 and 06/08/17. RN #1 stated, "It was a mistake on MOS part. We are supposed to look at the care plan. You go in room and look at her and she isn't really moving so you just forget to code the side rail as , restraints."

The Administrator and DON (.director of nursing) were informed of the above during a meeting with the survey team on 08/02/17 at 10:50 a.m. No further information was received prior to the exit conference on 08/02/17.

(1) Centers for Medicare and Medicaid Services, RAI (resident assessment instrument)Manual 3.0, Section P. Restraints, 2016.

F 279 483.20(d);483.21(b)(1) DEVELOP
SS=E **COMPREHENSIVE CARE PLANS**

F 279 8/18/17

483.20
(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

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(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to

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local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on, staff interview and clinical record review, the facility staff failed to develop comprehensive care plan for four of 27 residents, Resident #6 and #7.

1. Resident #6 did not have a comprehensive care plan to include incontinence interventions.

2. Resident #7 did not have a comprehensive care plan to include incontinence interventions.

3. Resident #2 had no care plan developed regarding nutritional needs including a history of significant weight loss.

4. Resident #19 had no care plan developed regarding vision.

Findings include:

1. Resident #6 did not have a comprehensive care plan to include incontinence interventions.

Resident #6 was admitted to the facility on 1/31/17 with a readmission on 3/15/17 with diagnoses including respiratory failure, acute kidney failure, sleep apnea, and obesity.

The most recent MOS (minimum data set) was a

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1. Residents! #6 and #7 incontinence care plan to be updated by 8/11/2017 to reflect additional individualized interventions. Nutritional focus care plan including history of weight loss was initiated for resident #2 on 8/1/17. Resident #191 s care plan was revised to reflect an independent focus for vision on 8/10/17.
2. A review of the care plan of current residents who are incontinent will be completed to ensure the presence of appropriate individualized incontinence interventions. A review of care plans for residents with recent weight loss and/or vision problem will be reviewed to ensure : the inclusion of separate individualized focus/goal/interventions on weight loss and vision. Any anomaly findings will be rectified accordingly.
3. Re-education of IDT staff with role in care plan updating/revision will be completed in the following areas:
a. Updating of care plans for patients who are incontinent, have weight loss and vision problems.
b. Timeliness of care plan updating with every change that affects other interventions on the care plan
c. General care plan initiation, revision,

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quarterly assessment with an ARD (assessment reference date) of 7/1/17. Resident #6 was assessed as being cognitively intact.

Resident #6's electronic record was reviewed on 8/1'/17 and evidenced, via comprehensive MOS dated 2/7/17, section "V" (Care Area Assessment) that Resident #6 had triggered for a care plan for incontinence. Section "H0400" (Bladder and Bowel) of the MOS also evidenced Resident #6 was "always incontinent."

Review of Resident #6's care plan did not evidence a care plan to include interventions with the exception of one intervention that read "Peri-care as needed."

On 8/1/17 at 2:00 p.m. the MDS coordinator (identified as registered nurse, RN #1) was interviewed. RN #1 reviewed Resident #6's care plan and verbalized that there should have been more interventions in place regarding incontinence and possible incontinent concerns for the certified nursing assistants to be aware of.

On 8/1/17 at 4:10 p.m. the above finding was brought to the attention of the director of nursing and administrator.

No further information was presented prior to exit conference on 8/2/17.

2. Resident #7 did not have a comprehensive care plan to include incontinence interventions.

Resident #7 was admitted to the facility on 6/7/17 with diagnoses including intracerebral hemorrhage, respiratory failure, end stage renal

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and updating
4. The DON/Designee will audit weekly x2 weeks, monthly x2 months, and quarterly x1 of all care plans for residents who are incontinent, with recent weight loss and vision problems. Unit Managers will conduct ongoing auditing to ensure accuracy and correctness of care plan focuses/goals/interventions weekly for one month, then monthly for two months, and then quarterly for two more quarters. Any deviations will be rectified accordingly. Findings will also be forwarded to the QA committee for further review and recommendations.
5. Date of compliance is August 18, 2017

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disease.

The most recent MOS (minimum data set) was a 30 day assessment with an ARD (assessment reference date) of 7/25/17. Resident #7 was assessed as being moderately cognitively intact.

Resident #l's electronic record was reviewed on 8/1/17 and evidenced, via comprehensive MOS dated 7/4/17, section "V" (Care Area Assessment), that Resident #7 had triggered for a care plan for incontinence. Section "H0400" (Bladder and Bowel) of the MOS also evidenced Resident #7 was "always incontinent."

Review of Resident #l's care plan did not evidence a care plan to include interventions with the exception of one intervention that read "Peri-care as needed."

On 8/1/17 at 2:00 p.m. the MOS coordinator (identified as registered nurse, RN #1) was interviewed. RN #1 reviewed Resident #l's care plan and verbalized that there should have been more interventions in place regarding incontinence and possible incontinent concerns for the certified nursing assistants to be aware of.

On 8/1/17 at 4:10 p.m. the above finding was brought to the attention of the director of nursing and administrator.

No further information was presented prior to exit conference on 8/2/17.

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3. Resident #2 had no care plan developed regarding nutritional needs including a history of significant weight loss.

Resident #2 was admitted to the facility on 7/6/12 with a re-admission on 5/31/16. Diagnoses for Resident #2 included Parkinson's disease, dysphagia with a gastric tube, high blood pressure and respiratory failure. The minimum data set (MOS) dated 5/15/17 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's clinical record documented an annual MOS dated 5/15/17. This MOS included nutrition in the care area assessment summary as a triggered care area requiring the development of a comprehensive care plan. Facility staff indicated on this MOS that a care plan would be developed for Resident #2's nutrition. Section K0300 of this MOS assessed Resident #2 had experienced a significant weight loss (loss of 5% or more in the last month or loss of 10% or more in last 6 months) and was not on a physician prescribed weight loss program. This MOS indicated the resident received 51% or more of his nutrition by tube feeding.

Resident #2's care plan (revised 5/29/17) included no problems, goals and/or interventions regarding nutrition or the resident's significant weight loss. The plan stated the resident ate nothing by mouth and required a gastric feeding tube for nutrition. Interventions were listed concerning care of the gastric tube but included no individualized problems, goals and/or interventions regarding overall nutrition or the assessed significant weight loss.

On 8/1/17 at 11:15 a.m. the registered dietitian

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(RD) and corporate nursing consultant were interviewed about Resid nt #2's nutrition care plan. The RD stated there was not a specific listing regarding weight loss. The RD stated her notes documented interventions in place regarding the resident's nutritional concerns including weight loss. The corporate nursing consultant stated the computerized care plan had references to notes that included interventions for the resident. The corporate nursing consultant stated the care plan would have too many pages if all the problems, goals and interventions were added to the care plan so they just referenced notes. On 8/1/17 at 1:35 p.m. the RD stated Resident #2's weight loss was recognized in February 2017 and May 2017 with labs obtained and adjustments were made to the resident's tube feeding formula. The RD stated the weight loss issue "was not specified" on the care plan.

These findings were reviewed with the administrator and director of nursing during a meeting on 8/1/17 at 4:10 p.m.

4. Resident #19 had no care plan developed regarding vision.

Resident #19 was admitted to the facility on 5/21/98 with diagnoses that included glaucoma, anxiety and high blood pressure. The minimum data set (MOS) dated 7/27/17 assessed Resident #19 with severely impaired cognitive skills.

Resident #19's clinical record documented an annual MOS dated 5/18/17. This MOS included vision in the care area assessment summary as a triggered care area requiring the development of a comprehensive care plan. Facility staff

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indicated on this MOS that a care plan would be developed regarding vision. Resident #19's clinical record documented a diagnosis of glaucoma. Resident #19 was prescribed and administered eye drop medications daily for the treatment of glaucoma.

Resident #19's care plan (revised 7/7/17) included no problems, goals and/or interventions regarding vision. The care plan listed the resident had a diagnosis of glaucoma under the area titled "Care Needs" but included no individualized goals or interventions regarding the resident's vision.

On 8/2/17 at 10:00 a.m. the registered nurse (RN #1) MOS coordinator responsible for care plan development was interviewed about Resident #19's vision plan. RN #1 stated the vision care area triggered for Resident #19 due to her diagnosis of glaucoma. RN #1 stated a care plan was usually developed for all triggered care areas on the MOS. RN #1 stated since the resident had no actual visual impairment a "stand alone" care plan was not developed or entered. When asked about any goals and/or interventions including monitoring the resident's glaucoma status to prevent visual impairment, RN #1 stated she was not sure what was done for Resident #2 other than administering medications as ordered. RN #1 stated no specific care plan had been entered regarding Resident's #19 vision.

These findings were reviewed with the administrator and director of nursing during a meeting on 8/2/17 at 10:50 a.m.

F 431 483.45(b)(2)(3)(g)(h) DRUG RECORDS, SS=D LABEL/STORE DRUGS & BIOLOGICALS F 431 8/18/17

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The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.?0(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(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.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
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.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in

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F 431	Continued From page 17 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) 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 and staff interview, facility staff failed to ensure expired drugs/biologicals were not available for use in one of four medication rooms in the facility; medication room on unit #3. Facility staff failed to discard expired drugs/biologicals in the medication room on unit #3. These include four bottles of Hydrogen Peroxide, two bottles of Isopropyl Alcohol and three bottles of Milk of Magnesia (MOM). Findings included: On 08/02/17 at approximately 8:15 a.m. LPN #1 {licensed practical nurse), Unit Manager and this surveyor inspected the medication room on unit #3. During this observation the following drugs/biologicals were located in the cabinet: Four bottles of Hydrogen Peroxide 3% - 16 fluid ounces, Expired 04/17; two bottles of Isopropyl Rubbing Alcohol 70% - 16 fluid ounces, Expired 07/17; and three bottles of MOM - 16 fluid ounces, Expired 06/17.	F 431	1. Expired drugs/biologicals (4 bottles hydrogen peroxide, 2 bottles of Isopropyl Alcohol, and 3 bottles of Milk of Magnesium) noted in the medication room on Unit #3 removed and discarded on 8/2/17. 2. Audit of medication rooms on the other Units (Unit #2, Unit #4, and Unit #5) completed on 8/2/17 with no further expired medication noted. 3. Re-education of Unit Managers/Central Supplies/Supervisors/Charge Nurses completed in the following areas: a. Routine monitoring and auditing of expiration date for clinical supplies, including medications and biologicals. 4. The DON/Designee will audit weekly x4 weeks, monthly x2 months, and quarterly x1 of all medication rooms for expired medication/biologicals. Any expired drugs/biologicals will be immediately discarded and findings forwarded to the QA committee for further	

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LPN #1 (Unit Manager) was immediately interviewed regarding who checks the medication room for expired medications and biologicals. LPN #1 stated, "I go through the stock. I missed it."

The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 08/02/17 at approximately 10:50 a.m. No further information was received prior to the exit conference on 08/02/17.

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recommendation.
5. Date of compliance is August 18, 2017

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

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F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at United Medical Nursing Center from November 29, 2016 through December 5, 2016. Survey activities consisted of a review of 40 residents' clinical records during Stage 1; and review of 30 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations *DIC* Discontinue DI - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center	F 000		

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

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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FOOD	Continued From page 1 HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record **MD-** Medical Doctor MOS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL- milliliters (metric system measure of volume) mg/di - milligrams per deciliter mm/Hg- millimeters of mercury **MN** midnight Neuro - Neurological NP - Nurse Practitioner PASRR- Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Pm - As needed Pt- Patient PU- Partial Upper PL- Partial Lower Q- Every QIS - Quality Indicator Survey Rp, RIP - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Trach- Tracheostomy TX- Treatment	F 000		
F 156 SS=D	483.10(b)(5)- (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally	F 156	1. **Resident #89** has been discharged. Could not retrospectively correct.	

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F 156	**Continued From page 2** **and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.** **The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.** **The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.** **The facility must furnish a written description of legal rights which includes:** **A description of the manner of protecting personal funds, under paragraph (c) of this section;**	F156	2. The medical records for all residents admitted/ readmitted since November 29, 2016, were audited to ensure proper notification of available services, charges or changes in charges for services not covered by Medicare, were audited. 3. To prevent future occurrences, SW staff will be in serviced on policy to ensure compliance and proper notification 4. Notification of available services, charges or changes in charges not covered by Medicare will be added as a Social Work audit quality indicator to ensure compliance until three months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the Administrator and presented at the Quarterly Quality Assurance Committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective Action Completion Date: 2/1/17	2/1/17

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F 156	Continued From page 3 A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of three (3) Stage 2 sampled residents, who were reviewed for Liability Notices and Beneficiary Appeals, it was determined that facility staff failed to provide one (1) resident the appropriate liability and/or appeal notices within the required time frame. Resident #89 The findings include: A review of the " Notice of Medicare Provider Non-Coverage " letter for Resident #89 revealed that his/her last day of Rehab [Rehabilitation] was August 5, 2016. The letter included a section for patient or representative signature indicating the notice was received. Resident #89 ' s signature was present and dated August 5, 2016 on the letter as being notified of discontinuation of rehab services. The dates recorded on the " Notice of Medicare Non-Coverage " lacked evidence that facility staff provided the resident notification of Medicare non-coverage within the required time frame of no later than two (2) days before the termination of services 42 CFR §405.12(b)(1) and 422.624(b)(1) and (2). A face-to-face interview was conducted on December 2, 2016 at approximately 3:00 PM with Employee #6. He/she acknowledged that the appropriate liability and/or appeal notice was not	F 156		

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	095039		12/05/2016

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F 156	**Continued From page 5** **provided** to **the resident within the required time frame. The clinical record was reviewed on December 2, 2016.**	F 156		
F **157** **SS=D**	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM,** ETC) **A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions** or clinical **complications); a need to alter treatment significantly (i.e., a need to discontinue an existing** form **of treatment due to adverse consequences, or** to **commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).** **The facility must also promptly notify the resident and, if known,** the **resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.** The **facility must record and periodically update the address and phone number of the resident's** legal **representative or interested family member.**	F 157	1. The weekly wound round sheets and medical record for **Resident #71** are routinely being reviewed to ensure proper notification as per policy requirements.(if required) Corrective action for **Resident #122** cannot be taken retrospectively in this instance. 2. Residents with changes in condition/injury/decline/room change/refusal of care have been identified since 11/29/16 for a medical record review to ensure use of proper notification procedure. 3. To prevent future occurrences, Nursing staff will be reeducated on the Falls policy with emphasis on proper notification 4. Proper notification of changes/injury/decline/room/refusal of care and or treatment, will be added as a quality indicator for review during daily stand-up meetings until three months of greater than or equal to 95% compliance is achieved. Results will be reported to the QAA committee by the DON	2/1/17 ongoing

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F 157	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 30 Stage 2 sampled residents, it was determined that facility staff failed to notify the physician when Resident #71 sustained an alteration in skin integrity and when Resident #122 refused to have diagnostic laboratory tests performed in accordance with physician ' s orders. Residents 71 and 122. The findings include: 1. Facility staff failed to notify the physician once Resident #71 was identified with altered skin integrity. According to a history and physical dated August 14, 2016, Resident# 71 had diagnoses which included: "CVA (Cerebral Vascular Accident), Hypertension, and Diabetes Mellitus." Review of Quarterly MOS (Minimum Data Set) dated November 4, 2016 revealed the following: Section G (Functional status) the resident was coded as needing limited assistance in Bed mobility, dressing and personal hygiene and the resident was totally dependent in bathing. Under Section I (Active Diagnosis) the resident was coded as having, Hypertension, Diabetes Mellitus, Hyperlipidemia, Cerebrovascular Accident (CVA), and Hemiplegia. Section M1040 (Other ulcers, wounds and skin problems) was coded None of the above indicating that he/she had no skin or foot problems present. Review of the Care Plan revealed the following:	F 157	5. Date of completion: 2/1/17	

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F 157	Continued From page 7 Plan of care dated/revised October 17, 2016, " Resident is at risk for complications related to Diabetes Mellitus. Resident will have no complications related to diabetes through the next review date. Check all of body for breaks in skin and treat promptly as ordered by doctor. Inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness. " Licensed nursing staff completed Weekly Skin assessment sheets using the facility ' s instructions as follows: "This sheet is to be used on all skin integrity alterations: Stoma sites (Enteral, Trach, Ostomy), Surgical sites, Pressure Ulcers ...Blisters. Skin Tear ...Rash and Discoloration. Upon discovery of the skin integrity alteration the licensed nurse must indicate/mark the skin impairment site(s) with an "X" then weekly in addition to the documentation in the nurse ' s note. " According to the Weekly Skin Sheets, nurse ' s identified skin impairment of Resident #71 ' s toes on the following dates: November 4, 8, 11, 15, 18 and 22, 2016. After review of the skin sheet assessments, it was noted that nursing staff first identified that Resident #71 had impairments to his/her toes on November 4, 2016. The nursing staff continued to note the impairment on subsequent assessments thru November 18th , however there was no follow up or interventions (such as notification of physician) initiated to address the concern from November 4 through 18, 2016. Additionally, there was no evidence of an assessment related to the characteristics of the resident ' s altered skin.	F 157		

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F 157	Continued From page 8 An Interim Physician's order dated November 21, 2016 at 4:13 PM directed: "Podiatrist consult with [Podiatrist Name/Physician #22] on November 22, 2016 at 3:30 PM." A podiatrist ' s [Physician #22] evaluation was conducted on November 22, 2016, the findings from the visit were as follows: "Patient presents for F/U (follow up) to ingrown toenails B/L (bilateral) foot, pain and swelling in both feet. Pain reported at level 10 (severe pain).Class findings: Nail changes- Thickening. Skin texture: thin, dry, tight and/or shiny. Edema. Paresthesia [burning or prickling sensation]. Burning ...Dermatological: Ascending cellulitis [bacterial infection of the skin] and erythema [superficial reddening of the skin]. B/L [bilateral] LE [lower extremity]. Nails 1-3 B/L foot thick, yellow, elongated, with subungual [collection of blood underneath a toenail] debris. Purulent [containing Pus] drainage from each toe. Incurvated toenails 1-3 B/L with granulomatous [small area of inflammation], proud flesh [swollen flesh that surrounds a healing wound] at medial border of B/L hallux (big toes). Moderate malodor [foul odor], severe dolor [pain], mild calor [heat]. Does not probe to bone. Does not undermine. Dry scaly plaques in moccasin distribution B/L soles of feet. Assessment: Cellulitis and abscess of foot ...Treatment Plan: Cultured purulent drainage and sent specimen to [Name of Laboratory Company]. Applied Gentamicin cream and DSD [Dry Sterile Dressing] to left foot wound. Patient must be admitted to hospital for IV [intravenous] antibiotics and vascular consult. Placed phone call to patient ' s PCP [primary care physician] regarding patient ' s condition and the	F 157		

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F 157	Continued From page 9 recommendation that patient be admitted to hospital for IV antibiotics and vascular consult." Subsequent to the Podiatry evaluation, the primary care physician initiated intravenous antibiotic therapy and wound treatments as follows: November 22, 2016 at 6:30 PM, "Zosyn [antibiotic] 2.25gm (gram) IV (intravenous) *QB* hours [every 8 hours], Vancomycin [antibiotic] 1gm IV Q [every] 24 hours. Trough at fourth dose. PICC (peripherally inserted central catheter) line placement for IV antibiotics. CBC (complete blood count), CMP (comprehensive metabolic panel), ESR (erythrocyte sedimentation rate) CRP (C-reactive protein) in **AM."** November 22, 2016 at 7pm, "Insert peripheral IV line to start Zosyn at 10pm" November 23, 2016 at 9:30am, "Give antibiotics Zosyn 2.25 gm IV Q 8 hours and Vancomycin 1 gm daily for 14 days for foot ulcer. November 23, 2016 at 10:20am, "Gentamycin cream 1% apply to infected area cover with dressing twice daily. Cellulitis" A face-to-face interview was conducted with Employees# 5, 7, and 23 (Licensed Nurses) on December 5, 2016 at 1:40 PM. When asked about the assessments of the resident *feeUtoes,* and lack of physician notification, the staff did not respond to the question. A face-to-face interview was conducted on December 5, 2016 at approximately 11:30 AM with Employees #2, and 21. After a review of the	F 157		

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F 157	Continued From page 10 clinical record, they acknowledged the findings. It was determined that facility staff identified impairment to the resident' s toes on November 4, 2016. Once identified, facility staff failed to assess and implement interventions in accordance with the resident ' s need for treatment. Subsequently, 18 days later, on November 22, 2016 the resident was seen by an external provider (podiatrist) who evaluated his/her feet and toes. The resident was found to have ascending cellulitis, erythema to bilateral lower extremities, purulent drainage from each toe, incurvated toenails with granulomatous, proud flesh at medial border of bilateral big toes, moderate malodor, severe pain and mild heat. The record was reviewed on December 2, 2016. 2. An interim Physician's Order dated and signed August 24, 2016 at 11:00 AM directed, " Ferrous Sulfate 325mg (milligram) (iron supplement) po (by mouth) daily, Repeat CBC (Complete Blood Count) in 1 (one) week. Elevated PLT (Platelet)." A review of the Physician's progress notes dated August 24, 2016 at 11:05 AM revealed, "Asked to review CBC, BMP (Basic Metabolic Panel) lab results; A/P (Assessment/Plan): Elevated Pit (Platelet) count ...Will start on ASA (Aspirin) ... (2) Hx (History) of iron deficiency [secondary chronic disease]. Will start on iron supplement daily, will monitor labs. Will follow up CBC lab results in one (1) week ... " The " Pathology Laboratory Final Report " dated August 31, 2016 revealed: "Ordered: CBC WO	F 157		

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F 157	Continued From page 11 (without) Differential; Comment: PT (Patient refused/ [staff named]). " A review of the nursing notes lacked evidence that the physician was notified when Resident #122 refused the diagnostic laboratory test. A face-to-face interview was conducted with Employee #4 on December 2, 2016 at approximately 11:30 AM. After reviewing the nurses ' notes, Employee #4 acknowledged that the resident refused the lab test and that facility staff did not notify the physician. The clinical record was reviewed on December 2, 2016.	F 157		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on resident interview, record review and staff interview for one (1) of 30 Stage 2 sampled residents, it was determined that facility staff failed to provide adequate notice prior to performing inter-facility room change. Residents' #52 and #101. The findings include: According to the facility ' s admission " Contract	F 247	1. The involved facility staff was reeducated for failure to provide notice to **resident #101** prior to a roommate change. 2. The records of residents involved in roommate changes, were audited to ensure proper notification. 3. To prevent future occurrences, Inservice will be provided to SW staff and clinical managers to ensure adequate notice is provided to residents prior to performing inter-facility room changes. 4. Resident notice (to include resident moving and new roommate), of room change will be added as a quality indicator for review	2/1/17

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F 247	Continued From page 12 Between Resident and United Medical Nursing Center", "... p 9 of 48; X(d) Miscellaneous Provisions ... ...Living Quarters and Roommates. The resident and the Responsible party (s) have the right to receive notice before the Resident ' s room or roommate is changed ..." According to the facility ' s policy regarding Room Changes, Policy No: AD02-034 within the Nursing Facility, " When room changes are requested or required, the resident and the responsible party will receive notice of the intended transfer from one room to another within the facility, or a change in roommate ... (4) When a decision is made, the Social Worker (or a designee) will contact the resident and the resident ' s family to inform them of the proposed room change ... (5). If there is no objection to the room change, the change and the adjustment of the resident to this change will be documented in the medical record. (6) Every attempt will be made to secure the permission of families and the residents involved. However, moves may be made without permission if the facility can document a clinical necessity for relocating the resident, such as a need for isolation or to address behavior management problem ... (7). In cases above, (6) the Social Worker will give written notification to all residents involved in the change ... The written notification will include a statement of the reasons for the transfer ... " A face-to-face interview was conducted on November 30, 2016 at approximately 2:29 PM with Resident #101 [residing in room #604A]. He/she revealed that he/she received a new	F 247	Indicator for review during daily stand-up meetings. The Quality Assessment and Assurance Committee will ensure oversight and correction of any identified issues. 5. Date of Correction: 2/1/17	ongoing

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F 247	Continued From page 13 roommate and was not given notice before the change. " Came in one day and the new roommate was in the other bed." A review of the clinical record for Resident #101 lacked evidence that the resident was provided notice before he/she received a new roommate. A review of an interim Physician's orders for Resident #52 dated March 9, 2016 at 1:30 PM directed; " Resident [#52] transferred from 6568 to 604A for administrative reason. " A face-to-face interview was conducted with Employee #8 on December 2, 2016 at approximately 12:00 PM. He/she stated, "The resident was told about receiving a new roommate, but it was not documented in the medical record." There was no evidence in the clinical record that facility staff provided notice to Resident #101 prior to a roommate change. The clinical record was reviewed on December 2, 2016.	F 247		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by:	F 253	1. The bulb in the light fixture for **room#616** and the deficient light switch were replaced. The torn privacy curtains have been replaced. 2. Environmental rounds were made on both Floors to ensure that all room lights were functional, light switches were operational and no loose, torn or	1/10/17

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F 253	Continued From page 14 Based on observations made on December 1, 2016 between 3:00 PM and 4:30 PM, it was determined that the facility failed to provide housekeeping services necessary to maintain an orderly interior as evidenced by torn privacy curtains in five (5) of 25 resident rooms, loose and detached privacy curtains in four (4) of 25 resident rooms, non-functioning lights in two (2) of 25 resident rooms, and a broken light switch in one (1) of 25 resident rooms. The findings include: 1. Privacy curtains were torn in five (5) of 25 resident rooms including room #603A, 621A, 701A and B, 708A and #744A and B. 2. Privacy curtains were hanging loose and off the hooks in four (4) of 25 resident rooms including room #603A and B, 606 A and B, 701B, 708A and B and #716B. 3. The light located above the handwashing sink in room #616 and the top bulb to the overhead light fixture in room #624 did not function when tested, two (2) of 25 resident rooms. 4. The light switch for the overhead light in room #624B was not working. These observations were made in the presence of Employee #15 and Employee #16 who acknowledged the findings.	F 253	torn privacy curtains. 3. A new "zone maintenance" program, for Facilities Management, has been implemented, assigning one maintenance technician responsibility for each floor for increased monitoring. Environmental Services will conduct daily rounds to ensure sanitary, comfortable and orderly interior. Environmental rounds for Facilities Management will be conducted a minimum of 2x per week. 4. The Director of Facilities Management (Maintenance) and the Director of Environmental Services will report the results of monitoring outcomes and plans for improvement to the Quality Assessment and Assurance. 5. Completion date: 2/1/17	ongoing ongoing
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		

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F 309	Continued From page 15 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: Based on record review and staff interview for three (3) of 30 Stage 2 sampled residents, it was determined facility staff failed to consistently monitor and implement interventions with timeliness to manage an alteration in skin integrity for Resident #71 which resulted in harm; the altered skin advanced to purulent (puss) drainage and paronychia (infection) of the resident's lower extremities (toes) that required intravenous antibiotic and wound treatment. Additionally, staff failed to clarify physician's orders for parameters of administration for an antihypertensive medication for one (1) resident and failed to consistently assess the neurological status for one (1) resident who sustained an unwitnessed fall. Residents' #71, #31, and #122. The findings include: 1. Facility staff failed to notify the physician once Resident #71 was identified with altered skin integrity. According to a history and physical dated August 14, 2016, Resident# 71 had diagnoses which included: "CVA (Cerebral Vascular Accident), Hypertension, and Diabetes Mellitus. " Review of Quarterly MOS (Minimum Data Set) dated November 4, 2016 revealed the following:	F 309	1. The weekly wound rounds sheets and medical record for **Resident #71** will be reviewed to ensure appropriate interventions, provision of necessary treatment and services. 2. An audit of all weekly skin sheets, bath and shower schedules, care plans was completed to ensure appropriate documentation of weekly skin/wound interventions. 3. To prevent future occurrences, reeducation will be provided to all nursing staff regarding assessments and documentation. Competencies for assessment of skin integrity and management of wounds competencies will be conducted for all licensed nursing staff. Weekly wound rounds, daily bath and shower sheets and nurses notes will be monitored by the Clinical Manager/designee to ensure appropriate interventions and appropriate documentation of variances. Clinical Manager/designee will also ensure appropriate documentation in resident care plan. Results of the monitoring will be forwarded to the DON by the Clinical Manager	1/17/17 1/25/17 1/31/17 2/1/17 On-going

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F 309	**Continued From page 16** **Section G (Functional status) the resident was coded as needing limited assistance in Bed mobility, dressing and personal hygiene and the resident was totally dependent** in **bathing. Under Section I (Active Diagnosis) the resident was coded as having, Hypertension, Diabetes Mellitus, Hyperlipidemia, Cerebrovascular Accident (CVA), and Hemiplegia. Section M1040 (other ulcers, wounds and skin** problems) was coded None of the above indicating that he/she had no skin or foot problems present. Review of the Care Plan revealed the following: Plan of care dated/revised October 17, 2016" Resident is at risk for complications related to Diabetes Mellitus. Resident will have no complications related to diabetes through the next review date. Check all of body for breaks in skin and treat promptly as ordered by doctor. Inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness. " Licensed nursing staff completed Weekly Skin assessment sheets using the facility ' s instructions as follows: "This sheet is to be used on all skin integrity alterations: Stoma sites (Enteral, Trach, Ostomy), Surgical sites, Pressure Ulcers ...Blisters. Skin Tear ...Rash and Discoloration. Upon discovery of the skin integrity alteration the licensed nurse must indicate/mark the skin impairment site(s) with an "X" then weekly in addition to the documentation in the nurse ' s note. " According to the Weekly Skin Sheets, nurse ' s identified skin impairment of Resident #71 ' s toes	F 309	4. The DON will report the monitoring outcome results and any action plans for improvement, to the quarterly Quality Assessment and Assurance Committee. 5. Completion date: 2/1/17 **Resident #31** **1.** The medication orders were reviewed and clarified with the physician to ensure that resident is receiving the medication within prescribed parameters **2.** MAR's of all residents receiving anti-hypertensive medications are being reviewed to ensure prescribed parameters are consistently followed. **3.** Inservice training will be provided to Licensed Nursing Staff by the Nurse Educator on Medication Administration and following parameters for administration. Audits will be conducted until 3 months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the QA/QA committee by the DON.	Ongoing 1/11/17 1/17/17 1/31/17 Ongoing

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F 309	Continued From page 17 on the following dates: November 4, 8, 11, 15, 18 and 22, 2016. Review of Weekly skin reports revealed the following: November 4, " **X** " mark located between big toe and second toe right and left foot November 8, " **X** " mark between big toe and second toe right foot, " **X** " mark on tip of second toe left foot. November 11, "X" mark on tip of second toe right foot and left foot November 15, " **X** " mark on base of big toe right foot, tip of second toe left foot November 18, " X" mark on tip of fourth toe right foot, base of second toe left foot November 22, " **X** " mark tip of 3rd toe right foot. Between big toe and second toe left foot After review of the skin sheet assessments, it was noted that nursing staff first identified that Resident #71 had impairments to his/her toes on November 4, 2016. The nursing staff continued to note the impairment on subsequent assessments thru November 18th, however there was no follow up or interventions (such as notification of physician) initiated to address the concern from November 4 through 18, 2016. Additionally, there was no evidence of an assessment related to the characteristics of the resident ' s altered skin in the nurse 's notes or clinical record. An Interim Physician's order dated November 21, 2016 at 4:13 PM directed: "Podiatrist consult with [Podiatrist Name/Physician #22] on November 22, 2016 at 3:30 PM."	F 309	4. Audit results and any action plans for improvement will be presented by the DON to the quarterly Quality Assessment and Assurance Committee 5. Completion date: 2/1/17 **Resident #122** **1. Resident #122** was not harmed by the deficient practice. **2.** Medical records of all residents sustaining a fall since 11/29/16 and forward, will be audited to ensure assessment of neurological status post-fall. **3.** Inservice training will be provided to all Nursing Staff on Post-Fall Documentation Requirements. Audits will be conducted until 3 months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the QA/QA committee by the DON. **4.** Audit results and any action plans for improvement will be presented by the DON to the quarterly Quality Assessment and Assurance Committee **5.** Date of completion: 2/1/17	Ongoing 1/17/17 2/1/17 on-going Ongoing

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F 309	Continued From page 18 A podiatrist ' s [Physician #22] evaluation was conducted on November 22, 2016, the findings from the visit were as follows: "Patient presents for F/U (follow up) to ingrown toenails B/L (bilateral) foot, pain and swelling in both feet. Pain reported at level 10 (severe pain). Class findings: Nail changes- Thickening. Skin texture: thin, dry, tight and/or shiny. Edema. Paresthesia [burning or prickling sensation]. Burning ...Dermatological: Ascending cellulitis [bacterial infection of the skin] and erythema [superficial reddening of the skin]. B/L [bilateral] LE [lower extremity]. Nails 1-3 B/L foot thick, yellow, elongated, with subungual [collection of blood underneath a toenail] debris. Purulent [containing Pus] drainage from each toe. lncurvated toenails 1-3 B/L with granulomatous [small area of inflammation], proud flesh [swollen flesh that surrounds a healing wound] at medial border of B/L hallux (big toes). Moderate malodor [foul odor], severe dolor [pain], mild calor [heat]. Does not probe to bone. Does not undermine. Dry scaly plaques in moccasin distribution B/L soles of feet. Assessment: Cellulitis and abscess of foot ...Treatment Plan: Cultured purulent drainage and sent specimen to [Name of Laboratory Company]. Applied Gentamicin cream and DSD [Dry Sterile Dressing] to left foot wound. Patient must be admitted to hospital for IV [intravenous] antibiotics and vascular consult. Placed phone call to patient ' s PCP [primary care physician] regarding patient ' s condition and the recommendation that patient be admitted to hospital for IV antibiotics and vascular consult." Subsequent to the Podiatry evaluation, the primary care physician initiated intravenous antibiotic therapy and wound treatments as	F 309		

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F 309	Continued From page 19 follows: November 22, 2016 at 6:30 PM, "Zosyn [antibiotic] 2.25gm (gram) IV (intravenous) *QB* hours [every 8 hours], Vancomycin [antibiotic] 1gm IV Q [every] 24 hours. Trough at fourth dose. PICC (peripherally inserted central catheter) line placement for IV antibiotics. CBC (complete blood count), CMP (comprehensive metabolic panel), ESR (erythrocyte sedimentation rate) CRP (C-reactive protein) in **AM."** November 22, 2016 at 7pm, "Insert peripheral IV line to start Zosyn at 10pm" November 23, 2016 at 9:30am, "Give antibiotics Zosyn 2.25 gm IV Q 8 hours and Vancomycin 1 gm daily for 14 days for foot ulcer. November 23, 2016 at 10:20am, "Gentamycin cream 1% apply to infected area cover with dressing twice daily. Cellulitis" A face-to-face interview was conducted with Employees# 5, 7, and 23 (Licensed Nurses) on December 5, 2016 at 1:40 PM. When asked about the assessments of the resident *feeUtoes,* and lack of physician notification, the staff did not respond to the question. A face-to-face interview was conducted on December 5, 2016 at approximately 11:30 AM with Employees #2, and 21. After a review of the clinical record, they acknowledged the findings. It was determined that facility staff identified impairment to the resident ' s toes on November 4, 2016. Once identified, facility staff failed to assess and implement interventions in	F 309		

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F 309	Continued From page 20 accordance with the resident ' s need for treatment. Subsequently, 18 days later, on November 22, 2016 the resident was seen by an external provider (podiatrist) who evaluated his/her feet and toes. The resident was found to have ascending cellulitis, erythema to bilateral lower extremities, purulent drainage from each toe, incurvated toenails with granulomatous, proud flesh at medial border of bilateral big toes, moderate malodor, severe pain and mild heat. The record was reviewed on December 2, 2016. 2. Facility staff failed to clarify physician's orders regarding the parameters of administration for an anti-hypertensive medication prescribed for Resident #31. Physician ' s Orders for October 2016 directed: [11] Hydralazine (anti-hypertensive) TAB (tablet) 25mg for: Apresoline (anti-hypertensive) 25mg- Take 1 tablet by mouth three times a day for hypertension -hold for blood pressure less than 120/60. [II] Review of the MAR (medication administration record) dated October 2016 revealed: "Hydralazine Tab 25mg by mouth three times a day for hypertension-hold for blood pressure less than 120/60." Hydralazine was administered to the resident with systolic blood pressures assessed below 120 during the month of October 2016 on the following days: 10/11/16 - 1pm blood pressure 114/71 10/20/16 - 1pm blood pressure 118/70 10/21/16- 5pm blood pressure 112/75	F 309		

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F 309	Continued From page 21 10/25/16- 1pm blood pressure 118/70 10/26/16 - 1pm blood pressure 117/74 Facility staff failed to clarify the prescribed parameters for the administration of Hydralazine. There was no evidence of differentiation between systolic and diastolic blood pressure assessments. On the blood pressures listed above, the systolic reading was less than the prescribed parameter (120), however; the diastolic level remained within range (above 60). There was no clear directive of when to hold the medication. A face-to-face interview was conducted on December 5, 2016 at 12:25 PM with Employee #2. He/she acknowledged the findings. The clinical record was reviewed on December 5, 2016. 3. Facility staff failed to consistently assess the neurological (neuro) status of Resident #22 who sustained an unwitnessed fall. The resident's neurologic status was monitored for a period of 12 hours post fall in contrast to the facility' s guidelines for the monitoring of neuro status for 72 hours post unwitnessed fall. According to the facility' s "Neuro Check Guideline ": Procedure No: 093, Reviewed Date: 1-6-2015, stipulates: "Subject: This checklist should be completed after the following intervals for follow up for all unwitnessed falls or falls in which head is struck. Any change in resident condition requires a phone call to the primary care physician. Initial assessment followed by q (every) 30 minutes [times] 4, every hour [times] 4, every four (4) hours [times] 24 hours, every 8 hours for 72 hours, or as ordered by the physician	F 309		

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F 309	Continued From page 22 ... (1) Vital signs: Assess blood pressure for increase or decrease, assess pulse for slowing or widening pulse, then increase rate, Assess respirations for change in rate, rhythm, pattern and rate of expiration ... " According to an admission MOS (Minimum Data Set) dated June 16, 2016 revealed Resident #122 diagnoses under Section I (Active Diagnoses) included: Hypertension, Depression, Generalized Muscle Weakness and Muscle Spasm. Section G0110 (Functional Status/Activities of Daily Living) revealed the resident was coded as needing limited assistance with one-person physical assist in transfers (how resident moves between surfaces, including to or from: bed, chair, wheelchair ...). A review of the Nurse ' s Notes revealed the following: "July 2, 2016 at 12 PM revealed," The resident's assigned CNA (Certified Nursing Assistant) reported that [he/she] saw the resident on the floor in a sitting position. Resident stated that [he/she] was trying to get in [his/her] wheelchair when [he/she] fell. On assessment, no injury noted... V/S (Vital signs)- 125/68, 78, 97.6, 18 ... " July 2, 2016- 11:00 PM- " S/P (Status Post) fall- alert, verbally responsive. [No] injury. Complained of pain 2/5- PRN (As needed) Tylenol (analgesic) was given which was effective. AOL (Activities of Daily Living) care provided. On neuro checks- [no injury]. V/S- 97.8-97-20-132/95, Oxygen (saturation)- 98%... " The" Neurological Assessment Record" dated July 2, 2016 (Time- 9AM) revealed neuro	F 309		

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F 309	Continued From page 23 assessments were conducted on the following times: July 2, 2016- 9AM July 2, 2016 - 9:15 AM July 2, 2016- 9:30 AM July 2, 2016- 9:45 AM July 2, 2016- 10:00 AM July 2, 2016-10:30 AM July 2, 2016- 11:00 AM July 2, 2016- 11:30 AM July 2, 2016- 12:00 PM July 2, 2013- 7 **[AM]-** [3 PM] July 2, 2016 - [3PM-11PM]- no neuro checks documented July 2, 2016- 9 PM There was no evidence that facility staff performed neuro checks on Resident #122 for 72 hours in accordance with the facility ' s neuro check guidelines. A face-to-face interview was conducted on December 5, 2016 at approximately 3:00 PM with Employee#4. After review of the aforementioned, the employee acknowledged the findings. The clinical record was reviewed on December 5, 2016.	F 309		
F 312 SS=D	483.25(a)(3) AOL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews for one (1) of 30 Stage 2 sampled residents, it was determined that facility staff failed to ensure that one (1) resident, who was unable to carry out activities of daily living [AOL], received the necessary care services to maintain oral hygiene. Resident #63. The findings include: A resident observation was conducted on November 30, 2016 at approximately 2:00PM. Resident #63 was observed in bed with his/her tongue protruding out of the oral cavity covered with dry white substance. A review of the annual MOS with an ARD (Assessment Reference Date) of October 2, 2016 revealed: "Section G - Functional Status: G0110 - J Personal hygiene - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers) for resident #63 was coded " 4 = total dependence - full staff performance every time during entire 7-day period. or dressing, toilet use and personal hygiene." According to Section I (Diagnoses) the resident was admitted to the facility with diagnoses which included Diabetes Mellitus, Hyperlipidemia, Cerebrovascular accident, Hemiplegia, Seizure Disorder and Respiratory Failure." A face-to-face interview was conducted with	F 312	1. Oral care for **resident#63** was provided. Resident was informed that oral-care will be provided and offered daily. 2. Residents are being assessed daily for ability to perform AOL's and adjustments to care plans have been made as indicated by the assessment. 3. To prevent future occurrences, CNAs will be reeducated on AOL's and provision of oral care. Providing Oral Care has been added to the Education Calendar. Personal care will be included in care plan discussions with resident, responsible party and nursing staff Competencies will be conducted for all licensed nursing staff. Management of skin integrity and wounds Inservices will also be conducted for all nursing staff. 4. The Director of Nursing will report the results of monitoring outcomes and plans for improvement, to the QAAC 5. Completion date: 2/1/17 and on-going	2/1/17 ongoing

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F 312	Continued From page 25 Resident #63 on November 30, 2016 at approximately 2:10 PM. During the interview the resident was queried whether he/she had received oral care. The resident responded, "Mouth need cleaning, not done today [indicating that staff had not provided the resident oral care]". The observation was made in the presence of Employee #5. The employee acknowledged the findings. Facility staff failed to provide routine oral care to Resident #63.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide services to prevent the development and progression of pressure ulcer(s) resulting in the development of 4 unstageable pressure ulcers and one (1) stage 2 pressure ulcer for Resident #81 who was admitted without skin impairment; this resulted in harm as evidenced by the progression of the ulcers to an advanced stage in the absence of consistent monitoring and effective treatment. Resident #81	F 314	**1.** Interventions were implemented to prevent the reoccurrence of skin tears/pressure ulcers **for Resident #81** 2. All high risk for skin breakdown residents, have been identified and skin assessments performed. Additionally the MDS, care plan, bath/ shower sheets and nurses notes, for this resident population, will be reviewed to ensure accurate documentation and coordination of care. 3. To prevent future occurrences, all licensed nursing staff will be inserviced on documentation of reassessment and re-evaluation of the Wound Management Treatment Plan.	

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F 314	Continued From page 26 The findings include: Resident #81 was admitted on September 23, 2016. According to the nurse ' s admission assessment dated September 23, 2016, the resident had no evidence of pressure ulcer(s) at the time of admission. Facility staff identified Resident #81 as a ' high ' risk for pressure ulcer development as identified on the Braden Scale assessment [a tool that was developed to help health professionals assess a patient's risk of developing a pressure ulcer] dated September 23, 2016. The physician ' s admission order included the following: " ...turn and position every 2 hours, toileting every 2 hours ... Weekly skin assessment on shower days by a licensed nurse on Mondays and Thursday; 11-7 shift ... " The physician ordered treatment for alteration in skin integrity as follows: "October 7, 2016 - ... Float both heels [every] shift due to SDTI (suspected deep tissue injury) 2) Monitor both heels [every] shift and report to MD (medical doctor). " " November 11, 2016 at 10:35 AM- Cleanse right buttocks wound with NSS (Normal saline solution) pat dry, apply Bacitracin ointment every day until healed."	F 314	4. Weekly wound rounds documentation will be monitored by the Wound Nurse Coordinator, who will review interventions for appropriateness, re-evaluate treatments and re-assess wounds for improvement or deterioration. The results of the monitoring outcomes and action plans for improvement, will be reported quarterly to the Quality Assurance, by the Director of Nursing. 5. Date of completion: 2/1/17	

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F 314	Continued From page 27 [11] November 12, 2016 at 3:00 PM- Cleanse open blister on the right and left legs lateral of the [shin] with NSS pat dry, apply Bacitracin ointment bid (twice a day) leave to open air until healed. [11] There was no evidence in the clinical record [nurse/physician progress notes] and/or facility documents [e.g. skin sheets] for Resident #81 that facility staff consistently monitored the resident ' s response to treatment once the resident was identified with skin impairment on October 7, 2016. There was no evidence of comprehensive characterization of the resident's heel and foot skin impairment, to include color, evidence of exudate or pain, wound bed and description of surrounding skin. The successive assessment of the resident ' s foot recorded on November 16, 2016 [nearly 5 weeks post initial observation by staff] identified a deterioration of the left foot wound, "unstageable SDTI.[11] The assessment of the right heel on November 16, 2017 lacked evidence of improvement. There was no evidence that staff identified the origin of the SDTI(s) and failure to heal. Additionally, there was no evidence that the treatment/provision of services for wound management was reevaluated /modified to promote healing and reduce the risk of additional skin impairment during the period of October 7, 2016 through November 16, 2016 as noted in the comprehensive care plan of October 7, 2016. The resident sustained additional skin impairment as noted below: Staff identified "open blister on the right and left legs ...no drainage" on November 12, 2016; however, there was no evidence of a comprehensive assessment [to include type of	F 314		

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F 314	Continued From page 28 ulcer, color, size, evidence of exudate or pain, wound bed and description of surrounding skin] of the alteration in skin integrity of the resident' s bilateral legs. The successive assessment conducted on November 16, 2016 [4 days later] revealed advanced stage impairments, that were identified as unstageable with slough. There was no evidence that staff assessed the site of impaired skin of the resident ' s sacrum for which the physician prescribed treatment on November 11, 2016. There was no record of a comprehensive wound assessment. A review of facility documents revealed licensed nurse ' s completed and signed two (2) forms to record residents' skin status: " Bath and Skin Report" and "Weekly Skin Assessment." A review of the "Bath and Skin Reports" for Resident #81 for the period of September 27 through November 14, 2016 revealed the forms were completed and signed by licensed nurses on shower days in accordance with physician ' s orders, however; there was no evidence of the identification of skin impairment for Resident #81 until November 15, 2016. In contrast, the physician prescribed treatment for altered skin integrity October 7, 2016. A review of the "Weekly Skin Assessment" forms for Resident #81 for the period of September 30 through November 14, 2016 revealed licensed nurses completed and signed the forms weekly, however; there was no evidence of the identification of skin impairment for Resident #81 until November 14, 2016. In contrast, the physician prescribed treatment for altered skin integrity October 7, 2016.	F 314		

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	095039		12/05/2016

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F 314	Continued From page 29 A comprehensive review of facility documents and staff interview are as follows: The nurse ' s readmission note dated September 23, 2016 at 8:00 PM revealed, "... Presence of surgical scar at the middle [of] the chest. Perinea! area intact with no area of skin impairment. An admission "Pressure Sore Evaluation Form" depicted on an anatomical image the resident had a PEG (Percutaneous Endoscopic Gastrostomy) tube site and a surgical scar in the center of the chest. There were no other documented skin impairment(s)." The history and physical was completed on November 5, 2016 revealed, "Problems Feeding Dysfunction, recent GT [gastrostomy tube] placement, CAD (coronary artery disease), DM (diabetes mellitus), CVA (Cerebral Vascular Accident) and HTN (Hypertension). In addition, the resident ' s skin condition was not addressed by the physician." The Braden Scale (Used for predicting pressure sore risk] for Resident #81 revealed the following assessments: September 23, 2016 -assessed at 12 indicating that the resident was high risk for pressure sore. September 30, 2016, assessed at 13 indicating that the resident was not at risk for developing a pressure sore. October 7, 2016- assessed at 13 indicating that the resident was not at risk for developing a pressure sore.	F 314		

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F 314	Continued From page 30 October 14, 2016- assessed at 13 indicating that the resident was not at risk for developing a pressure sore. October 21, 2016 revealed that the resident was assessed at 12 indicating that the resident was high risk for pressure sore. According to a significant change MOS (Minimum Data Set) dated October 1, 2016 revealed, under Section G (G0110- Activities of Daily Living (AOL) Assistance) the resident was coded as (3) requiring that the resident needed extensive assistance in bed mobility and required one (1) person to physical assist. The resident was totally dependent in transfers, dressing, toileting, eating, personal hygiene and bathing and required one (1) person physical assist. Section G0400 (Functional Limitation and Range of Motion) Resident #81 was coded as having impairment to both lower extremities in addition to an impairment to one upper extremity. Section M- Skin Conditions, revealed the resident was coded in M0150 as at risk for pressure ulcers and had no pressure, venous or arterial ulcers. Section H-Bladder and Bowel, indicated Resident #81 was always incontinent of bowel; and had an indwelling Foley catheter. Section I (Active Diagnosis) revealed the resident's diagnoses included: Diabetes Mellitus, Hyponatremia, Cerebral Vascular Accident, Hypertension, Hemiplegia, Dementia, and Coronary Artery Disease. Care Plan: Review of the care plan titled, "Resident has potential for skin tear related to incontinence and limited mobility" initiated on October 5, 2016	F 314		

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F 314	Continued From page 31 revealed ...Interventions: identify potential causative factors and eliminate/resolve mean possible. Resident uses pressure relieving mattress, pillows to protect the skin while in bed ... " Care Plan October 7, 2016 "...actual impairment to right heel related to suspected deep tissue injury [SDTI] ...Interventions: monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs & symptoms of infection, maceration to MD [medical doctor] ... " An Interim Physician's Order directed the following: November 16, 2016 at 3:30 PM- D/C [discontinue] all pervious wound treatment orders. (2) Wash the sacral wound with soap and water, pat dry, apply Calmoseptine ointment (an analgesic, antiseptic, and skin protectant used for preventing and treating minor skin irritations). (3) Sites: right and left lateral leg wounds- cleanse with wound cleanse pat dry apply Santyl ointment (collagenase enzyme that breaks down collagen in damaged tissues within the skin and helps the body to generate new healthy tissue.) Cover daily until healed; (4) site rt [right] heel and left lateral foot- Apply skin prep every shift until resolved. November 16, 2016 at 3:35 PM "...air mattress for the healing of and for the prevention of new pressure ulcers ... " A review of the nursing notes revealed the following: " October 7, 2016 at 11pm ... CNA (Certified	F 314		

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F 314	Continued From page 32 Nursing Assistant) was taking residents weight, [he/she] discovered discoloration on resident right heel. On assessment, suspected deep tissue injury was noted on resident ' s right heel measuring 8x2 cm and on left foot lateral measuring 5x5 cm with no open sore. Nurse Practitioner [named] was made aware and RP (responsible party) was notified, resident feet was floated per physician's orders.. November 12, 2016- 11:00 PM- Resident was noted with open blister on the right and left legs lateral to the shin, both open blisters were noted with no drainage. Open blisters were assessed, vital signs taken, MD (medical doctor) notified and new order given ... November 19, 2016- 8:00 AM- ... alert and responsive, on tube feeding via pump with Diabetic Source. No residual volume noted. Remains on 02 (oxygen) via NC (nasal cannula) at 2 LPM (liters per minute), Sat(saturation) at 98%, No [shortness of breath] noted. T-(Temperature) 98.8 .... " The clinical record lacked evidence that the licensed nurse consistently assessed and monitored Resident #81 's skin after being informed of the discoloration of the right heel and left lateral foot by the CNA. There was a lapse of 35 days before any subsequent skin assessments were documented in the nursing notes. According to Resident #81's bath and skin report sheets dated September 30, 2016; October 6, 10, 13, 17, 20, 24, 26, 27, 2016; and November 10, 2016 were marked as indicating there was no identified skin impairment on these dates.	F 314		

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F 314	Continued From page 33 Weekly Skin Assessment sheet dated September 27, 2016; October 3, 6, 10, 2016; November 3, 7, 10, 2016 were marked as no "areas of skin impairment " According to the weekly skin assessment dated September 27, 2016; October 3, 6, 10, 13, 2016; and November 3, 7, 10, 2016 depicted the resident had no skin impairment on these dates. According to the wound nurse notes dated November 16, 2016 at 4:00 PM revealed the following: "Wound #1: Sacrum healing stage 2 pressure injury (partial thickness skin loss with exposed dermis) has pink wound bed and flushed edges.1cmx2cmx0.1cm, Calmoseptine ordered. Wound # 2 is located on the right lateral leg measures 8x3.5x utd (unable to determine) Depth cannot be determined due to wound covered by 50% slough (defined as dead tissue separating from living tissue; especially a mass of dead tissue separating from an ulcer). Wound edges attached. No drainage. Will heal with Santy!. Wound #3 is located on the right heel. This is a suspected deep tissue injury (purple or maroon area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear) measuring 4.7x4.8x utd (unable to determine) depth covered by thin eschar with a notes pink, black purple color. No drainage at this time. Will treat with skin prep. Wound #4 is located on the left lateral leg with	F 314		

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F 314	Continued From page 34 100% necrotic yellow slough. Margins are attached. Scant serous drainage noted no odor. Santyl ordered for treatment. Wound #5 is located on the left lateral foot which is a dark discolored unstageable SDTI (suspected deep tissue injury) and measures 4x4 depth cannot be determined. Surrounding tissue is intact and dry. Will treat with skin prep. No noted clinical infection on any of the wounds. Will continue to follow, Air mattress ordered. Resident is T CR (total care), with heels floated. " There was no evidence in the clinical record that a pressure reduction mattress was implemented once the resident was assessed with a high risk of developing skin breakdown as stipulated in the facility' s skin care policy. The pressure reduction mattress, according to the Physician ' s Orders was not ordered until November 16, 2016, a total of 39 days had lapsed between initial finding and implementation of an air mattress for Resident #81. A face-to-face interview was conducted on December 5, 2016 at approximately 4:45 PM with Employees # 2, #3 and #18. The Employees acknowledged the findings. The clinical record lacked evidence that facility staff consistently assessed and monitored the condition of Resident #81 's skin although the resident was identified as "high risk" for skin breakdown. Once the resident sustained an alteration in skin integrity, there was no evidence that staff assessed and notified the medical team of the effectiveness of treatment or failure to heal as outlined in the comprehensive care plan. Subsequently, additional ulcers developed and	F 314		

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F 314	**Continued From page 35** **once assessed, determined to be at advanced stages [unstageable]. Resident #81 sustained four (4) facility acquired, unstageable pressure injuries and a Stage 2 sacral ulcer. The record was reviewed December 5, 2016.**	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observations made on December 1, 2016 between 3:00 PM and 4:30 PM, it was determined that the facility failed to maintain resident environment free of accident hazard as evidenced by a damaged handrail located across from the dining room on the 7th. floor. The findings include: The handrail located across from the dining room on the seventh floor had a perforation with jagged edges and posed an accident hazard to residents, staff and visitors. This observation was made in the presence of Employee#15 and Employee #16 who acknowledged the findings.	F 323	1. The damaged handrail had been repaired. 2. Environmental rounds were made on both Floors to ensure that all handrails were not damaged. 3. A new "zone maintenance" program has been implemented, assigning one maintenance technician responsibility for each floor. This will include Environmental rounds that will be conducted a minimum of 2x per week. 4. The Director of Facilities Management (Maintenance) will report the results of monitoring outcomes and plans for improvement to the Quality Assessment and Assurance. 5. Completion date: 2/1/17	ongoing
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	**F 371**		

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F 371	**Continued From page 36** **The facility must -** **(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and** **(2) Store, prepare, distribute and serve food under sanitary conditions** This REQUIREMENT is not met as evidenced by: Based on observations made on November 29, 2016 at approximately 9:30 AM, it was determined that the facility failed to store foods under sanitary conditions as evidenced by: 10 of 10 one-pint containers of 2% white milk, three (3) of three (3) one-pint containers of 2% chocolate milk and 12 of 12 half-pint containers of 2% white milk that were stored beyond their expiration date in cooler #4 and a misplaced thermometer in one (1) of four (4) food coolers. The findings include: 1. 10 of 10 one-pint containers of 2% white milk and three (3) of three (3) one-pint containers of 2% chocolate milk stored in a plastic storage bin in cooler #4 were expired as of 11/28/2016. 2. 12 of 12 half-pint containers of 2% white milk stored in the same plastic storage bin in cooler #4 were expired as of 11/27/2016. 3. There was no thermometer available in	F 371	1. All expired milk was discarded immediately after being identified during the survey. The broken thermometer was replaced immediately 2. All milk to be discarded will be placed in a container labeled "For Discard Donat Use" 3. To prevent future occurrences, the container used to discard expired milk, will monitored to ensure that it is properly labeled. Staff will be inserviced to ensure compliance. Visual checks of thermometers will be conducted daily. Any damaged and or malfunctioning thermometers will be replaced immediately. 4. Monitoring of the expired milk storage container and thermometers will be conducted daily by the department Director/designee and results of the monitoring will be reported quarterly to the Quality Assessment and Assurance Committee by the Director/Designee. 5. Completion Date: 2/1/17	2/1/17 ongoing

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F 371	Continued From page 37 cooler #1, to confirm the internal temperature in one (1) of four (4) coolers. These observations were made in the presence of Employee #13 and/or Employee #14 who acknowledged the findings.	F 371		
F 412 SS=D	483.SS(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on family, resident and staff interviews and record review for three (3) of 30 Stage 2 sampled residents, it was determined that facility staff failed to follow-up and/or provide recommended dental services for one (1) resident; failed to follow-up on one (1) resident's eligibility for new dentures in a timely manner and failed to follow up on a post dental evaluation and assist one (1) resident in obtaining dental repair. Residents' #40 #47 and #113. The findings include:	F412	1. Follow-up has been initiated for **Resident #47** to obtain recommended dental services (Dentures) 2. An audit of all current residents identified as needing services from an outside resource, will be completed to ensure follow-up of recommendations and receipt of services in a timely manner.. Moving forward, this audit will be conducted on all newly admitted residents 3. Reeducation will be provided to the nursing staff regarding the importance of follow-up on recommendations from Dentist and other outside resources. Records of residents receiving services from outside resources or in-house appointments will be audited daily. Results of the audit will be reviewed at daily stand-up meeting until 3 months of greater than or equal to 95% compliance is achieved. Results of the monitoring will be forwarded to the DON	1/31/17 1/31/17 and on-gain g

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F 412	Continued From page 38 1. Facility staff failed to follow-up and/or provide recommended dental services for Resident #40. A telephone interview was conducted with Resident #40 ' s responsible party on November 30, 2016 at approximately 11:59AM. The responsible party was asked the following question, " Does [Resident #40] have any problems with [his/her] teeth, gums, or dentures? He/she responded," Yes, [he/she] has plaque buildup. The responsible party further stated, that staff is not taking care of these problems to [his/her] satisfaction." A review the of the Dental Treatment Notes revealed the following: " June 16, 2015- Complete Oral exam/Oral cancer screening. TX (Treatment) plan: FMX (Full mouth x-ray) and FMD (Full Mouth Debridement), Ext (Extract) #18 ... August 13, 2015- Spoke to RP (Responsible Party) today regarding treatment plan. He/she accepts [regarding] FMD (Full Mouth Debridement). March 23, 2016- Complete Oral Exam/Oral Cancer Screening. Pt (Patient) will need mild sedation for extraction and FMD (Full Mouth Debridement). Today, RP has not left consent even though discussed previously. No TX (treatment) to begin until consent received. "	F 412	4. The DON will report the results of this review with any action plans for improvement, quarterly, to the Quality Assessment and Assurance Committee. 5. Completion Date: 2/1/17 !. Follow-up has been initiated for **Resident #40** to obtain recommended dental services (Full Mouth Debridement, Extraction) 2. An audit of all residents identified as needing dental care, which requires signed consent prior to care, will be conducted to ensure follow-through in obtaining consent and initiating care 3. To prevent future occurrences, Inservice training will be provided to licensed staff regarding the importance of follow-up on orders and plans for care (such as obtaining required consent). Obtaining required consents will be added to the monthly chart audit tool. Results of the audit will be provided to the Administrator by HIM. 4. The HIM coordinator will report the results of the audit at the quarterly QA/QA committee meeting until 3 consecutive months of greater than or equal to compliance is achieved	Ongoing 1/31/17 2/1/17 Ongoing

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F 412	Continued From page 39 There was no documented evidence that the dentist followed up with the responsible party regarding the resident's oral status from March 23, 2016 to November 30, 2016. A face-to-face interview was conducted with Employee #4 on December 2, 2016 at approximately 1:00 PM. Employee #4 stated, [he/she] will have to follow-up with the dentist regarding the treatment plan. A telephone interview was conducted with Employee #20 on December 5, 2016 at approximately 1:00 PM regarding Resident #40 ' s treatment plan. He/she stated, that he/she distinctly remember talking to the responsible party regarding the treatment plan and needing a consent to complete the treatment. Further stated, that [he/she] left the consent forms with the nurses ' and informed them that the responsible party will be coming in to sign the consent. A follow-up telephone interview was conducted with Resident #40 ' s responsible party at approximately 2:00 PM on December 5, 2016 in the presence of Employee #4. The RP was queried whether [he/she] had discussed with the dentist the need for a signed consent to complete the treatment plan for the resident ' s tooth being extracted and a full mouth debridement. He/she responded," No, I don't recall having a conversation with the dentist. I did not know he/she (the dentist) was waiting for me to sign a consent." **A** face-to-face interview was conducted with	F 412	5. Date of completion: 2/1/16 **1.** Follow up has been initiated to obtain dental repair for **Resident #113.** 2. An audit of all current residents identified as needing services from an outside resource, will be completed to ensure follow-up of recommendations and receipt of services in a timely manner. Moving forward, this audit will be conducted on all newly admitted residents. 3. Inservice education will be provided to the Nursing staff regarding the importance of follow-up post evaluation/provision of services by outside resources. Records of residents receiving services from outside resources or in-house appointments will be audited daily. Results of the audit will be reviewed at daily stand-up meeting until 3 months of greater than or equal to 95% compliance is achieved. Results of the monitoring will be forwarded to the DON. 4. The DON will report the results of this review with any action plans for improvement, quarterly, to the Quality Assessment and Assurance Committee.	

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F 412	Continued From page 40 Employees ' # 1 and #2 on December 5, 2016 at 2:30PM. Both acknowledged the dental treatment was not done secondary to not having the responsible party ' s signed consent. Employee #2 stated, he/she would follow-up with the dentist and the responsible party. The clinical record was reviewed on December 5, 2016. 2. Facility staff failed to follow-up on Resident #47's eligibility status to obtain new dentures in a timely manner. During a face-to-face interview with Resident #47 on November 30, 2016 at approximately 11:50 AM, the resident disclosed that his/her dentures have been missing since last year. He/she had made the facility aware but had not heard anything about it since. The resident said that [he/she] would like to have the lost dentures replaced. A review of Resident #47's dental records revealed that his/her last dental exam was completed on March 23, 2016. There was no mention of his/her dentures. Further review of the resident ' s dental records revealed that a previous dental exam was done on June 16, 2015 with the following notes: "Previous denture lost in facility Pt. [patient] requests new toothbrush and new denture. Eligibility to be checked to determine if denture	F 412	5. Date of Completion: 2/1/17	

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	095039		12/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 412	Continued From page 41 eligible." There was no further documentation in the resident ' s medical records to suggest that his/her eligibility status to replace his/her lost dentures were ever explored. A face-to-face interview on December 2, 2016 at approximately 12:25 PM with Employee #17. He/she stated that [he/she] was not aware that Resident #47 had lost [his/her] dentures. When queried regarding Resident #47' s meal intake, Employee #17 responded that the resident meal intake was good. A review of Resident #47's last quarterly nutritional assessment dated November 21, 2016 revealed that his/her meal intake was consistently above 75%. A face-to-face interview with Employee #8 was conducted on December 2, 2016 at approximately 12:30 PM. Employee #8 said that he/she did not know that Resident #47 had dentures since he/she had only been employed at the facility since April 2016. 3. Facility staff failed to follow up on a post dental evaluation and assist the resident in obtaining dental repair. Resident #113. On November 30, 2016 at 3:00 PM Resident #113 was observed and noted to have several chipped/broken teeth as well as missing teeth in the anterior mouth. The resident was admitted to the facility on	F 412		

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F 412	Continued From page 42 January 7, 2016 and was seen by the dentist on March 23, 2016. The dental report dated March 23, 2016 revealed the following: "Complete Oral Exam ... pt. [patient] will need mild sedation ... Xt. [Extract] #6, 7, 9, 10, 19, 30 - 32. P/U/PL[Partial/Upper/Partial Lower] dentures. TX [Treatment] to begin once consult rec'd [received]. " There was no evidence that a consult was received from March 23, 2016 to present, in reference to dental treatment plan for Resident # 113. Further review of the resident ' s clinical record failed to reveal any evidence that an appointment was scheduled for dental treatment. A face-to-face interview was conducted with Employee #4 at approximately 3:00 PM on December 2, 2016. The employee was queried whether they [the staff] had scheduled a dental treatment appointment for the resident with the dentist. The employee was directed to the dental report/recommendation in the clinical record. Employee #4 acknowledged that the facility staff failed to follow up post dental evaluation and assist the resident in obtaining dental treatment. The record was reviewed on December 2, 2016.	F 412		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		

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F 441	Continued From page 43 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on a staff interview and review of employee records for eight (8) of 10 newly hired employees, it was determined that facility staff failed to maintain an infection control program designed to help prevent the development and transmission of disease and infection as evidenced by: a failure to ensure that eight (8) of	F 441	**1. Employee #24** had provided proof of a negative chest x-ray which was misfiled in the employee file and therefore not found during survey. **Employee# 25** has a positive titer on file. The physician validation form will be completed by 1/17/17 **Employee #26** did not complete the Hepatitis B series vaccinations. Employee will restart vaccination series no later than 1/17/17. Remaining 2 vaccines will be provided per CDC guidelines **Employee#27** did provide proof of a negative chest x-ray upon hire which was misfiled in the employee file and not found during survey.	1/12/17 1/17/17 1/17/17 1/12/17

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F 441	**Continued From page 44** **10 newly hired employees were screened for communicable disease such as, Mycobacterium Tuberculosis (TB) upon hire and prior to providing direct care to residents** in **the facility. Employees' #24, #25, #26, #27, #28, #29, #30, and** #31. **The findings include:** **Centers for Disease Control (CDC's) Prevention Guidelines for Preventing the Transmission** of **Mycobacterium Tuberculosis (TB) in Health Care Setting, 2005. Morbidity and Mortality Weekly** Reports **(MMWR)** 2005:54(RR17); 1-141 stipulates: "Two-step testing with the Mantoux tuberculin skin test (TST) should be used for baseline or initial testing. Some people with latent TB infection have a negative reaction when tested years after being infected. The first TST may stimulate or boost a reaction. Positive reactions to subsequent TSTs could be misinterpreted as a recent infection. " <https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm> "TB Screening Procedures ... all HCWs (health care workers) should receive baseline screening upon hire ...HCWs should receive TB screening annually (i.e., symptom screen) for all HCWs and testing for infection with M. tuberculosis for HCWs with baseline negative test results...HCWs with a baseline positive or newly positive...should receive one chest radiograph result to exclude TB disease. Instead of participating in serial testing, HCWs should receive a symptom screen annually".	F 441	**Employee #28 did not** complete the PPD tuberculin skin testing as noted during survey. Employee will restart the testing series no later than 1/17/17 and will return for the 2nd testing in the series within the time frame specified by organization policy (2/10/17) **Employee #29** did not complete the Hepatitis B series vaccinations. Employee will restart vaccination series no later than 1/17/17. Remaining 2 vaccines will be provided per CDC guidelines. A Physician titer validation form will be obtained. If the employee has decided not to continue series, a waiver form will be completed **Employee#30** did not complete the Hepatitis B series vaccinations. Employee will restart vaccination series no later than 1/17/17. Remaining 2 vaccines will be provided per CDC guidelines. A Physician titer validation form will be obtained. If the employee has decided not to continue series, a waiver form will be completed	1/17/17 1/17/17 1/17/17

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F 441	Continued From page 45 http://www.immunize.org/askexperts/experts_hepb.asp#hcw "Persons who cannot provide written documentation of a complete hepatitis B vaccination series should complete the 3-dose series, then be tested for anti-HBs 1 to 2 months after the final dose." 1. The facility failed to ensure that Employee #24 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #24 ' s personnel file revealed the following: Job Title: Registered Nurse Date of Hire: August 1, 2016 There was no evidence that Employee #24 was offered or received the two-step Purified Protein Derivative (PPD) skin test [a test that determines if you suffer from tuberculosis], a chest x-ray or the Tuberculosis Symptom Screening Questionnaire prior to or upon employment. 2. The facility failed to ensure that Employee #25 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #25 ' s personnel file revealed the following: Job Title: Registered Nurse	F 441	**Employee #31** titers will be redrawn to assure immunity. If the results indicate no immunity, the employee will be offered the series of vaccinations. If the employee declines, a waiver will be obtained. 2. All employee files are being audited to ensure compliance. Any deficiencies will be corrected immediately and employees will have until 1/31/17 to fulfill requirements. Any deficiency wherein an employee wishes to receive a series of vaccinations, will be provided within guidelines recommended by the Centers for Disease Control 3. To prevent future occurrence and moving forward, Occupational Health will ensure that all required pre-employment screens are completed per policy, before clearance to hire by monitoring records. Exception will be made when a vaccination series is required. A tickler file will be used to ensure tracking and completion	1/17/17 1/24/17 1/31/17 and ongoing

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F 441	Continued From page 46 Date of Hire: August 1, 2016 There was no evidence that Employee #25 was offered the Hepatitis B Vaccinations, or received the Hepatitis B vaccination series. 3. The facility failed to ensure that Employee #26 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #26 ' s personnel file revealed the following: Job Title: Certified Nursing Assistant Date of Hire: August 8, 2016 Employee #26 ' s " Hepatitis B Immunizations " record indicated, Vaccination #1 date given May 19, 2016, Vaccination #2, date given July 25, 2016, Vaccination #3 date given was left blank (indicating not given.) A review of the July 25, 2016 Anti HBS test revealed, Negative (Non-reactive): Patient is considered to be not immune to infection with HBV (Hepatitis B Vaccine). 4. The facility failed to ensure that Employee #27 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #27 ' s personnel file revealed the following:	F 441	4. The Director of Outpatient Clinics and Health Services/designee will report the results of the new hire monitoring, monthly to the Administrator and quarterly at the QA/QA committee 5. Date for completion: 2/1/17	

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F 441	Continued From page 47 Job Title: Certified Nursing Assistant Date of Hire: August 8, 2016 Employee #27 ' s "Assessment for Tuberculosis In Positive Tuberculin Skin Test (TST) Reactions " was left blank (indicating not done.) 5. The facility failed to ensure that Employee #28 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #28 ' s personnel file revealed the following: Job Title: Registered Nurse Date of Hire: July 18, 2016 There was no evidence that Employee #28 was offered and received the 2nd PPD. 6. The facility failed to ensure that Employee #29 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #29 ' s personnel file revealed the following: Job Title: Registered Nurse Date of Hire: August 1, 2016 Employee #29' s "Hepatitis B Immunizations indicated: Vaccination #1 date given: 8/1/16,	F 441		

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F 441	Continued From page 48 Vaccination #2, and Vaccination #3 was left blank, no evidence that the employee received the second and third vaccinations. The " Hepatitis B Vaccination/Post-Exposure Evaluation was not signed. 7. The facility failed to ensure that Employee #30 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #30 ' s personnel file revealed the following: Job Title: Certified Nursing Assistant Date of Hire: August 1, 2016 Employee #30 's "Hepatitis B Immunizations indicated: Vaccination #1 date given: 7/26/16, Vaccination #2, and Vaccination #3 were left blank, no evidence that the employee received the second and third vaccinations. A review of the Anti HBS (Hepatitis B Surface) test dated 7/19/16 revealed, Negative (Non-reactive): Patient is considered to be not immune to infection with HBV. 8. The facility failed to ensure that Employee #31was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #31 ' s personnel file revealed the following: Job Title: Certified Nursing Assistant Date of Hire: August 1, 2016	F 441		

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F 441	Continued From page 49 Employee #31 's " Immunization and Screening record " revealed Hepatitis HBAB (Hepatitis B Surface Antibody) Titer was POS [positive] on June 18, 2012. However, there was no lab record showing the results of the titer and that the employee was immune. A face-to-face interview was conducted on December 5, 2016 with Employee #11 at approximately 3:30 PM. After review of the aforementioned records. He/she acknowledged the findings.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made on November 29, 2016 at approximately 9:30 AM and on December 1, 2016 at approximately 2:00 PM, it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by one (1) of one (1) dishwashing machine that failed to maintain a minimum final rinse temperature of 180 degrees Fahrenheit, two (2) of eight (8) torn air curtains from the dishwashing machine and one (1) of two (2) freezers with a broken door latch. The findings include:	F 456		

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F 456	**Continued From page 50**	F 456	1. The facility immediately switched to paper dishes and the Dish repair contractor was contacted. Machine was repaired on 12/2/16. Hobart Repair and Maintenance had already been called and were on-site to repair torn air curtains at time of survey. Air curtains have been repaired. Freezer door latches will be repaired. 2. The facility immediately switched to paper dishes and the Dish Machine was repaired on 12/2/16. Hobart Repair had already been called and were on-site to repair the torn air curtains at the time of the survey and they have been repaired 3. Preventive maintenance and service checks will be conducted monthly to ensure timely identification of any issues 4. Results of the monthly maintenance and monitoring will be provided to the Administrator and reported by the Dietary Director at the quarterly Quality Assessment and Assurance committee meeting. 5. Date of Completion: 2/1/17	ongoing Ongoing
	1. **One (1) of one (1) dishwashing machine failed to maintain a final rinse temperature of 180 degrees Fahrenheit on December 1, 2016 at approximately 2:00 PM. The final rinse temperature gauge reached 194 degrees Fahrenheit briefly and dropped to a maximum temperature of 173 degrees Fahrenheit during several wash cycles.** **A face-to-face interview was conducted with Employee #13 on December 1, 2016 at approximately 2:30 PM. Employee #13 decided that the facility would use paper dishes to serve all meals until the dish machine is repaired and contacted (Dish machine repair contractor).** **At approximately 10:30 AM on December 2, 2016, the dish machine was repaired, dishes were cleaned and disinfected and Chinaware was used to serve lunch meals.** 2. **Two (2) of eight (8) air curtains located at the front and back of** the **dishwashing machine were** torn. 3. **The door to freezer #2, one (1) of two (2) walk-in freezer in the main kitchen failed to latch when closed.** **These observations were made in the presence** of **Employee #13 and/or Employee #14 who acknowledged the findings.**			
F 463 SS=D	**483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH** **The nurses' station must be equipped to receive resident calls through a communication system**	F 463		

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F 463	Continued From page 51 from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations made on December 1, 2016 between 3:00 PM and 4:30 PM, it was determined that the facility failed to maintain call light in good working condition as evidenced by defective call bells in two (2) of 25 resident rooms. The findings include: The call bell in the bathroom of room #726 and the call bells in room #637 (Beds A and B) did not function as intended in two (2) of 25 resident rooms. These observations were made in the presence of Employee #15 and Employee #16 who acknowledged the findings.	F 463	1. The call bell in the bathroom for **#726** has been repaired. The call bells for (Beds A and B) FOR ROOM **#637** have been repaired 2. Call bells for all rooms on the SNF units have been inspected for working order. 3. To prevent future occurrences, a new call bell system has been purchased for the SNF unit. A new "zone maintenance" program has been implemented, assigning one maintenance technician responsibility for each floor. Environmental rounds will be conducted a minimum of 2x per week. 4. The Director of Facilities Management (Maintenance) will report the results of monitoring outcomes and plans for improvement to the Quality Assessment and Assurance. 5. Completion date: 2/1/17	2/1/17 Ongoing ongoing
F 514 SS=D	483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514		

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F 514	**Continued From page 52** **resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.** This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30 Stage 2 sampled residents, it was determined that facility staff failed to accurately record the incidence of one (1) resident's behavior on the Psychoactive Medication Monthly Flow Record. Resident# 92. The findings include: Facility staff failed to accurately record behavior problems for Resident #92 on the Psychoactive Medication Monthly flow record. Physician ' s Orders for September, October and November, 2016 directed the following: " Citalopram (Celexa) 20mg tab, Administer 1 tablet by mouth one time a day for Depression. Divalproex (Depakote) 500mg Administer 1 tablet by mouth one time a day for Behavior Disorder. Trazodone 50 mg Administer 1 tablet one time a day at bedtime for sleep. Lorazepam injectable 2mg/ml (Ativan injectable Administer 0.5ml (1mg) intramuscularly four (4) times a day as needed for agitation." Review of the Medication Administration Record **(MAR)** for September, October and November, 2016 revealed that the Resident #92 had been taking the above mentioned medications as ordered.	F 514	1. **Resident# 92** was not harmed by the deficient practice. The involved nursing employees were reeducated regarding the failure to accurately code the psychoactive monthly medication flow record. 2. Medical records for all residents on psychoactive medications will be reviewed to ensure accurate documentation? 3. To prevent future occurrences, Inservice training will be provided to nursing staff to ensure accurate documentation in residents 'record 4. Audits of up to 25 randomly selected charts, will be conducted monthly on records of residents on psychoactive medication with behavior issues. Audits will be conducted until 3 months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the QA Committee by the DON. 5. Date of completion: 2/1/17	1/10/17 2/1//17 2/1/17

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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 514	Continued From page 53 Resident ' s Care Plan last updated November 8, 2016 revealed, "The resident has a behavior problem r/t combative behaviors, restlessness, agitation, and resistant to AOL (activities of daily care). Resident spit on staff when trying to give care or administer medications, refusal of labs, refusal of medications The intervention was listed as " Administer medications as ordered, Monitor/document for side effects and effectiveness. The instruction/guidance listed on the Psychoactive Medication Monthly Flow Record for September, October and November 2016 revealed, " Record the number of episodes of Behavior, Intervention utilized and outcome. Side effects are documented on the reverse of this page. Additional information is documented in Nursing Progress Notes. Section 1: Target Behavioral Symptoms " . According to the September 2016 Psychoactive Medication Monthly flow record, facility staff were monitoring the resident for " Agitation and Insomnia " . Number of episodes, Interventions, and Outcomes "marked as zero indicating that the behavior had not occurred. According to the October 2016 Psychoactive Medication Monthly Flow Record, facility staffs were monitoring the resident for "Hitting and Resistance to care " . Number of episodes, Interventions, and Outcomes "marked as zero indicating that the behavior had not occurred. According to the November 2016 Psychoactive Medication Monthly flow record, facility staff were monitoring the resident for "Agitation and Insomnia " . Number of episodes, Interventions,	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	{X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095039		12/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

(X4)1D 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)	(XS) COMPLETION DATE
F 514	Continued From page 54 and Outcomes " marked as zero indicating that the behavior had not occurred. Review of nursing notes for September, October and November 2016 revealed the following: Nursing note dated September 9, 2016 revealed, " ...Resident is appeared to be combative, refusing care spitting at staff. Resident was noted being resistant and verbally abusive ... " Nursing note dated September 14, 2016 revealed, " ...resist care, calling staff names/threats ... " Nursing note dated October 19, 2016 7:04 **AM** revealed, " Resident refused incontinence care at this time." Nursing note dated October 19, 2016 at 7:38 AM revealed, " Resident refused labs " . Nursing note dated November 12, 2016 at 9:00 AM revealed, "Refused annual flu vaccine" . Nursing note dated November 22, 2016 at 6:00 AM revealed, "Resident refused UA (Urinalysis) x3." November 29, 2016 [no time indicated]" ...the resident refused and started hitting the writer in the head ...NP (Nurse Practitioner) instructed the writer to document the actions of the resident. " Facility staff failed to accurately code Psychoactive Medication Monthly flow record for September, October and November 2016 when the Resident #92 exhibited behaviors reflected in nursing notes. A face-to-face interview was conducted on December 5, 2016 at 12:25 PM with Employee #2. He/she acknowledged the findings. The record was reviewed on December 5, 2016.	F 514		
F 520	483.75(0)(1) QM	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING___ B. WING___	(X3) DATE SURVEY COMPLETED
	095039		12/05/2016

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F 520 SS=D	**Continued From page 55** **COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS** **A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.** **The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.** **A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.** **Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.** This REQUIREMENT is not met as evidenced by: Based on review of the Quality Assessment and Assurance (QAA) sign in sheets and staff interview, it was determined that facility staff failed to ensure that a physician was included in all the QAA meetings held at the facility. The findings include:	F 520	1. Physician attendance at Quality Assessment and Assurance committee meetings has been addressed with the Medical Director. 2. Physician attendance at the Quality Assessment and Assurance committee has been addressed with the SNF Medical Director and the Hospital Director of Hospital Quality 3. To prevent future occurrences, meeting schedules will be coordinated with the Medical Director, who will ensure physician attendance. 4. Physician attendance at all Quality Assessment and Assurance committee meetings will be monitored and reported to the Director of Hospital Quality/Chief Medical Officer for appropriate follow up as indicated. 5. Completion Date: 2/1/17 and ongoing	Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
	095039		12/05/2016

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F 520	Continued From page 56 The QAA (Quality Assessment and Assurance) interview was conducted on December 5, 2016 at approximately 3:15 PM with Employee #1. Employee #1 stated that the QAA program was restructured in March and April 2016 and QAA meetings were conducted in the months of May, July, and October, 2016. Employee #1 was asked to provide the sign in sheets for those meetings to determine whether the required members attended the meetings Review of the sign in sheets for July 2016 revealed that there were no physicians in attendance. This was confirmed during the review by Employee #1.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495121		R-C 08/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYDALE HEALTH AND REHABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207

(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)	(XS) COMPLETION DATE
	{F 000} INITIAL COMMENTS	{F 000},		
	An unannounced Medicare/Medicaid revisit to the standard survey conducted 06/28/2016 through 06/30/2016, was conducted 08/16/2016 through 08/17/2016. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Corrected deficiencies are identified on the CMS 2567-B. No complaints were investigated. The census in this 240 certified bed facility was 216 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents #101 through #118).			
	{F 271} 483.20(a) ADMISSION PHYSICIAN ORDERS SS=E . FOR IMMEDIATE CARE	{F 271}		8/29/16
	At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and review of facility documents, the facility staff failed for one of 18 residents in the survey sample (Resident # 103) to ensure physician's orders were obtained upon admission for the care of the resident's colostomy. There were no specific orders for the care of Resident# 103's colostomy, which he had on admission to the facility. The findings were: Resident# 103 in the survey sample, a 43 year-old male, was admitted to the facility on 7/18/16 with diagnoses that included diabetes		The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility s allegation of compliance. All alleged deficiencies cited have been or will be	

-- ✓ ··1<1FC TOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

08/24/2016

vith an asterisk (*) denotes a deficiency which the institution *may* be excused from correcting providing it is determined that 1t protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days .,er or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ;uments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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{F 271} Continued From page 1

mellitus, chronic kidney disease, hypertension, status post colostomy placement, and Fournier's Gangrene (a bacterial infection of the skin that affects the genitals and perineum). According to the Initial Minimum Data Set with an Assessment Reference Date of 7/25/16, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Under Section H (Bladder and Bowel), at Item H0100 - Appliances, the resident was assessed as having a colostomy.

Review of Resident# 103's paper clinical record as well as his Electronic Health Record revealed the following order, dated 7/18/16, "Colostomy care every shift for colostomy care and as needed for colostomy care." As of the date of record review, 8/17/16, which was 30 days after admission to the facility, there were no specific orders for the care of the colostomy, including the irrigation of the colostomy, care of the stoma, wafer and pouch, emptying of the pouch, and cleaning of colostomy appliances.

At approximately 3:30 p.m. on 8/17/16, the surveyor requested and received from the Director of Nursing two policies regarding colostomy care. The first policy, Colostomy Care, notes the following, "Colostomy stoma/wafer/pouch will be applied/changed by a licensed nurse as ordered by physician." The second policy, Colostomy Irrigation, notes that, "Colostomy irrigation will be done by a licensed nurse with order of the physician."

During an end of day meeting at 4:00 p.m. on 8/17/16, with the survey team and the

{F 271},

corrected by the date or dates indicated.

F 271

1. Resident # 103 colostomy order clarified on 8/22/2016
2. An audit of all residents with colostomy will be conducted to determine the orders on colostomy care are complete.
3. Re-education of Nursing Staff on placing complete colostomy orders for nurses to include changing colostomy and wafer.
4. DON/UM/Designee to will audit orders on all residents with colostomy on ongoing basis; weekly x4 weeks, monthly x2 months, and quarterly x2 more quarters. Any anomaly will be corrected and then forwarded to the.QA committee for further sustained resolution.
5. Date of compliance is August 29, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
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{F 271} Continued From page 2

{F 271}

administrative staff, colostomy care for Resident # 103 was discussed. The Corporate Nurse Consultant indicated that there should be specific orders for the care of Resident# 103's colostomy.

{F 279} 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

{F 279} 8/29/16

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on clinical record review and staff interview, the facility staff failed for one of 18 residents in the survey sample (Resident #103) to develop a plan of care to address the use of a colostomy. There was no provision in Resident# 103's care plan to address his colostomy use, which he had on admission to the facility.

F279

1. Resident# 103 care plan updated to include colostomy on 8/17/2016
2. Review of the care plan of all residents with colostomy will be conducted to ascertain its inclusion in the comprehensive care plan. Incomplete

{F 279} Continued From page 3

The findings were:

Resident# 103 in the survey sample, a 43 year-old male, was admitted to the facility on 7/18/16 with diagnoses that included diabetes mellitus, chronic kidney disease, hypertension, status post colostomy placement, and Fournier's Gangrene (a bacterial infection of the skin that affects the genitals and perineum). According to the Initial Minimum Data Set with an Assessment Reference Date of 7/25/16, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Under Section H (Bladder and Bowel), at Item H0100 - Appliances, the resident was assessed as having a colostomy.

At approximately 3:00 p.m. on 8/17/16, the surveyor requested and received from the Director of Nursing (DON) a copy of Resident# 103's care plan. A thorough review of Resident # 103's care plan failed to reveal any mention of his colostomy, or any provisions for the care of his colostomy. Following surveyor review of the care plan, the DON was advised of the lack of a care plan to address Resident# 103's colostomy.

During an end of day meeting at 4:00 p.m. on 8/17/16, with the survey team and the administrative staff, the lack of a care plan to address Resident# 103's colostomy was discussed.

{F 279}

care plan will be updated on colostomy use.
3. Re-education of Nursing Staff on initiating care plan on colostomy care for resident with colostomy.
4. DON/UM/Designee to will audit the care plan on all residents with colostomy on ongoing basis; weekly x4 weeks, monthly x2 months, and quarterly x2 more quarters. Any anomaly will be corrected and then forwarded to the QA committee for further sustained resolution.
5. Date of compliance is August 29, 2016

{F 281} 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS
SS=D

{F 281} 8/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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{F 281} Continued From page 4

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to follow professional standards of nursing for one of 18 residents, Resident #114.

Facility staff did not flush a gastrostomy tube with water prior to the administration of medications for Resident #114.

Findings were:

Resident #114 was most recently readmitted to the facility on 07/01/2015. His diagnoses included but were not limited to: Multiple sclerosis, dysphagia, cerebrovascular disease, heart failure, dementia, peripheral vascular disease and anemia.

The most recent MOS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/05/2016. Resident #114 was assessed as having a cognitive summary score of "03", indicating severe impairment with his cognitive status.

At approximately 8:00 a.m., on 08/17/2016, this surveyor approached LPN (licensed practical nurse) #1 about observing a medication pass for Resident #114. LPN #1 stated that the next medications would be given at 8:30 a.m., and for this surveyor to return then. This surveyor returned at 8:30 a.m. to conduct the observation. When this surveyor arrived at Resident #114's

{F 281}

F281

1. Resident #1141 s nurse on 8/17/2016 was re-educated on flushing feeding tube prior to further medication administration.
2. Feeding tube Med pass will be conducted on nurses to ensure nurses are following professional standards of practice.
3. Re-education of the nursing staff will be completed to include following professional standards of nursing practice for flushing feeding tube before and after medication administration.
4. DON/Unit Managers/Designee will complete med pass on feeding tube patients weekly for one month, then monthly for two months, then quarterly for two more quarters to ascertain nurses completion of feeding tube flushes prior to med/feeding administration. Any deviation will be forwarded to the QA committee for resolution/recommendation.
5. Date of compliance is August 29, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
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{F 281}	Continued From page 5 room, a facility policy and procedure for "Feeding Tubes" was observed on top of the medication cart. This surveyor asked LPN #1 about the policy. He stated, "We review the policies from time to time." LPN #1 was then observed preparing the 9:00 a.m. medications to be administered via Resident #114's gastrostomy tube. LPN #1 and this surveyor entered the room together. Observed at the bedside was a tube feeding pump with Osmolite 1.2 tube feeding infusing at 75 cc per hour, continuously. LPN #1 placed the prepared meds on a table at the foot of the bed. He obtained a green "Antibacterial" bag from the pole holding the tube feeding pump. He removed. a 60 cc syringe from the bag and a plastic container. He then disconnected the tube feeding from the gastrostomy tube and placed the tube feeding line into the green bag, he did not turn off the pump. He then closed the port on the gastrostomy tube. LPN #1 checked Resident #114's feeding tube for proper placement by injection air into the resident's stomach and listening with his stethoscope. He then checked for residual stomach contents. LPN #1 then began to administer the 9:00 a.m. medications one by one. He did not flush the gastrostomy tube with water prior to administering the medications. After the medications were complete, LPN #1 flushed the tube with 75 cc of water. He reconnected the tube feeding to the gastrostomy tube. He poured the tube feeding that had accumulated in the green bag into the sink, washed the bag out and returned the syringe and plastic container to the green bag. The facility policy was requested. According to	{F 281}		

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	495121		R-C **08/17/2016**

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{F 281} Continued From page 6

{F 281}

the facility policy "Feeding Tubes" the following procedure should be followed: "... 3. Disconnect feeding tube [gastrostomy tube] from feeding [tube feeding] if applicable. 4. Verify tube placement and residual amounts. 5. Place end of feeding bag tube on an opened clean **"4X4** gauze" sponge or place cap over tube as indicated. 6. Connect the tip of the 60 cc syringe to the end of the tube and flush via gravity using 30 cc-60 cc of water, or as prescribed by physician PRIOR to instillation of medications..."

LPN #1 was interviewed at approximately 2:30 p.m. regarding the administration of medications earlier that morning (08/17/2016). He stated, "I didn't flush before I gave the medications because I didn't have an order to do that...it was a mistake to put the tube feeding into the green bag to run...I should have turned it off."

The above information was discussed during an end of the day meeting with the DON (director of nursing) the administrator and two nurse consultants. They were asked if an order was needed to flush the gastrostomy tube with water prior to the administration of medications. The nurse consultant stated, "No order is needed to flush the tube before giving medications...that is a standard of practice...It should have been flushed."

A copy of the facility's reference for nursing standards for gastrostomy tube care was requested and received. The facility's reference, Clinical Nursing Skills & Techniques 8th Edition Potter and Perry, pages 501 -503, "Administering Medications Through an Enteral Feeding Tube", outlined step by step instructions for the technique to be used during medication

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{F 281} Continued From page 7

{F 281}

administration via a gastrostomy tube. Step 11 on page 501 addressed flushing the tube prior to the administration of medications: "11. Irrigate the tubing. a Pinch or clamp enteral [gastrostomy] tube and remove syringe. Draw up 30 ml of water into syringe . Reinsert tip of syringe into tube, release clamp, and flush tubing....Rationale: Pinching or clamping tuning prevents leakage or spillage of stomach contents. Flushing ensure that tube is patent." (1)

No further information was recei ed prior to the exit conference on 08/17/2016.

(1) Potter, Perry. Clinical Nursing Skills & Techniques 8th Edition. Mousy. St. Louis, **Missouri.**

{F 322} 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS
SS=D

{F 322} 8/29/16

Based on the comprehensive assessment of a resident, the facility must ensure that -

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

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{F 322} Continued From page 8

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to provide proper treatment and services for the care of a gastrostomy tube for one of 18 residents, Resident #114.

Facility staff failed to ensure a gastrostomy tube was patent by flushing with water prior to the administration of medications

Findings were:

Resident #114 was most recently readmitted to the facility on 07/01/2015. His diagnoses included but were not limited to: Multiple sclerosis, dysphagia, cerebrovascular disease, heart failure, dementia, peripheral vascular disease and anemia.

The most recent MOS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/05/2016. Resident #114 was assessed as having a cognitive summary score of "03", indicating severe impairment with his cognitive status.

At approximately 8:00 a.m., on 08/17/2016, this surveyor approached LPN (licensed practical nurse) #1 about observing a medication pass for Resident #114. LPN #1 stated that the next medications would be given at 8:30 a.m., and for this surveyor to return then. This surveyor returned at 8:30 a.m. to conduct the observation.

{F 322}

F322
1. Resident#114I snurseon8/17/2016 was re-educated on flushing feeding tube prior to further medication administration.
2. Feeding tube Med pass will be conducted on nurses to ensure nurses are following professional standards of practice.
3. Re-education of nursing staff will be completed to include flushing feeding tubes before and after administration of medications or feeding.
4. DON/Unit Managers/Designee will complete med pass on feeding tube patients weekly for one month, then monthly for two months, then quarterly for two more quarters to ascertain nurses, completion of feeding tube flushes prior to med/feeding administration. Any deviation will be forwarded to the QA committee for resolution/recommendation.
5. Date of compliance is August 29, **2016**

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	495121		**08/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE. ZIP CODE
CHERRYDALE HEALTH AND REHABILITATION CENTER	**3710** LEE **HIGHWAY** **ARLINGTON, VA 22207**

(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)	(XS) COMPLETION DATE

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When this surveyor arrived at Resident #114's room, a facility policy and procedure for "Feeding Tubes" was observed on top of the medication cart. This surveyor asked LPN #1 about the policy. He stated, "We review the policies from time to time." LPN #1 was then observed preparing the 9:00 a.m. medications to be administered via Resident #114's gastrostomy tube.

LPN #1 and this surveyor entered the room together. Observed at the bedside was a tube feeding pump with Osmolite 1.2 tube feeding infusing at 75 cc per hour, continuously. LPN #1 placed the prepared meds on a table at the foot of the bed. He obtained a green "Antibacterial" bag from the pole holding the tube feeding pump. He removed a 60 cc syringe from the bag and a plastic container. He then disconnected the tube feeding from the gastrostomy tube and placed the tube feeding line into the green bag, he did not turn off the pump. He then closed the port on the gastrostomy tube. LPN #1 checked Resident #114's feeding tube for proper placement by injection air into the resident's stomach and listening with his stethoscope. He then checked for residual stomach contents.

LPN #1 then began to administer the 9:00 a.m. medications one by one. He did not flush the gastrostomy tube with water prior to administering the medications. After the medications were complete, LPN #1 flushed the tube with 75 cc of water. He reconnected the tube feeding to the gastrostomy tube. He poured the tube feeding that had accumulated in the green bag into the sink, washed the bag out and returned the syringe and plastic container to the green bag.

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: The facility policy was requested. According to the facility policy "Feeding Tubes" the following procedure should be followed: "... 3. Disconnect feeding tube [gastrostomy tube] from feeding . [tube feeding] if applicable. **4.** Verify tube placement and residual amounts. 5. Place end of feeding bag tube on an opened clean **"4X4** gauze" sponge or place cap over tube as indicated. 6. Connect the tip of the 60 cc syringe to the end of the tube and flush via gravity using 30 cc-60 cc of water, or as prescribed by physician PRIOR to instillation of medications..."

LPN #1 was interviewed at approximately 2:30 p.m. regarding the administration of medications . earlier that morning (08/17/2016). He stated, "I didn't flush before I gave the medications because I didn't have an order to do that...it was a mistake to put the tube feeding into the green bag to run...I should have turned it off."

The above information was discussed during an end of the day meeting with the DON (director of nursing) the administrator and two nurse consultants. They were asked if an order was needed to flush the gastrostomy tube with water prior to the administration of medications. The nurse consultant stated, "No order is needed to flush the tube before giving medications...that is a standard of practice...It should have been flushed."

A copy of the facility's reference for nursing standards for gastrostomy tube care was requested and received. The facility's reference, Clinical Nursing Skills & Techniques 8th Edition Potter and Perry, pages 501 -503, "Administering Medications Through an Enteral Feeding Tube", outlined step by step instructions for the

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	technique to be used during medication administration via a gastrostomy tube. Step 11 on page 501 addressed flushing the tube prior to the administration of medications: "11. Irrigate the tubing. a Pinch or clamp enteral [gastrostomy] tube and remove syringe. Draw up 30 ml of water into syringe . Reinsert tip of syringe into tube, release clamp, and flush tubing....Rationale: Pinching or clamping tuning prevents leakage or spillage of stomach contents. Flushing ensure that tube is patent." (1)			
	No further information was received prior to the exit conference on 08/17/2016.			
	. (1) Potter, Perry. Clinical Nursing Skills & Techniques 8th Edition. Mousy. St. Louis, Missouri.			
F 514 SS=D	483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F514		8/29/16
	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.			
	The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
	This REQUIREMENT is not met as evidenced by:			

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F 514	Continued From page 12 Based on observation, staff interview and clinical record review, the facility staff failed to maintain an accurate record for one of 18 residents, Resident #115. On 08/16/2016 and 08/17/2016, LPN (licensed practical nurse) #2 recorded a compression sleeve was applied to Resident #115's left arm when it had not been applied. Findings were: Resident #115 was most recently readmitted to the facility on 06/07/2016. His diagnoses included but were not limited to: Bacterial pneumonia, Type II Diabetes mellitus, bipolar disorder, cellulitis, and dysphagia. The most recent MOS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/15/2016. Resident# 115 was assessed as having a cognitive summary score of "00", indicating severe impairment with his cognitive status. The electronic medical record was reviewed on 08/17/2016. Observed on the POS (physician order sheet) was the following order: "May use TED hose as compression sleeve for left arm edema, every day shift". The order was dated 06/17/2016. Resident #115 had been observed lying in his bed on 08/16/2016 at approximately 1:40 p.m., a TED stocking was not present on his left arm at that time. On 08/17/2016 a medication observation was conducted with LPN (licensed practical nurse) #2.	F 514	F514 1. Resident #115 order for compression sleeve clarified on 8/17/2016. Physician order obtained for compression sleeve to be use as needed on 8/17/2016. 2. An audit of all residents with active compression sleeve order will be conducted to determine that appropriate orders are in place. Those not in compliance wiUbe updated accordingly. 3.. Re-education ofnursi11g staff wflrbe completed on appropriate assessment and order for residents with compression sleeve. 4. The DON/Unit Manager or designee will audit all patients with compression sleeve on an ongoing basis weekly for one month, then monthly for two months, **then quarterly for two more quarters. Any** deviations will be forwarded to the QA committee for resolution. 5. Date of compliance is August 29, 2016.	

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ATED stocking was not on his left arm. The left hand was observed as contracted.

The electronic medical record was again reviewed on 08/17/2016 at approximately 1:15 p.m. The TAR (treatment administration record) was reviewed. The entry: "MAY USE TED HOSE AS COMPRESSION SLEEVE FOR LEFT ARM EDEMA every day shift" was initialed and checked for the date 08/16/2016 and 08/17/2016

LPN #2, who had initialed the TAR as applying the TED hose to Resident #115's left arm was interviewed. She was asked what her initials and check mark beside an item on a MAR (medication administration record) or TAR signified. She stated, "That means that it is done...the medication has been given or the treatment has been completed." LPN #2 was asked about the TED hose for Resident #115's left arm. LPN #2 went to the computer and pulled up the order. She stated, "That is an honest mistake...! thought it was PRN [as needed]...I didn't put it on today." LPN #2 was asked if she had applied the TED the previous day [08/16/2016]. She stated, "No." LPN #2 was asked why she had initialed the entry on the TAR indicating the treatment was done if she had not applied the TED hose to Resident #115's left arm. She stated, "If you don't check it off the computer turns it red, meaning it was not done...I signed it off so it would not turn red....everything needs to be green [meaning it is completed] by the end of the shift."

No further information was obtained prior to the exit conference on 08/17/2016.

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F 000	INITIAL COMMENTS	F 000		
	An unannounced Medicare/Medicaid standard survey was conducted 06/28/16 through 06/30/16. An extended survey was conducted 06/29/16 through 06/30/16. Immediate Jeopardy was identified in the area of Quality of Care at a Scope and Severity Level 4, pattern which constituted Substandard Quality of Care. Significant 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 240 certified bed facility was 229 at the time of the survey. The survey sample consisted of 31 current Resident reviews (Residents 1 through 27 and Residents 31 through 34) and 3 closed record reviews (Residents 28 through 30). The expanded survey sample consisted of 4 current Resident reviews (Residents 31 through 34).			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical r1;3cord review, facility staff failed to follow guidelines for use of physical restraints for one of 34 residents in the survey sample, Resident #30.	F 221	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited	8/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/21/2016

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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1. Facility staff failed to obtain informed consent for use of a lap buddy restraint*, failed to conduct a nursing assessment before applying restraint, and failed to obtain a physician order prior to applying physical restraint on Resident #30.

* A lap buddy is a device that fits on top of the resident's lap and hooks through the wheelchair handles. It feels like a thick cushion and is covered with vinyl or plastic. The ends of the lap buddy fit through the openings of the wheelchair handles and curve around the front bar of the handles. The lap buddy is thicker than the opening of the wheelchair handles so you have to compress it to get it through the openings. It fits very snuggly.

Findings included:

1. Facility staff failed to obtain informed consent for use of a lap buddy restraint, failed to conduct a nursing assessment before applying restraint, and failed to obtain a physician order prior to applying physical restraint on Resident #30.

Resident #30 was admitted to the facility on 03/14/2015 with diagnoses including, but not limited to: Fractured Right Humerus, Osteoarthritis, Joint Pain, Alzheimer's Disease, Dysphagia, Depression, Dementia with Behaviors and a History of Falls.

The most recent MOS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/24/2016. Resident #30 was assessed as severely impaired in her cognitive status with a total cognitive score of four out of 15.

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in support of the alleged deficiencies. The!
facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility! s, allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.

F221 Cross Reference to 12 VAC 5-371-330 (A)
1. Resident #30 hospitalized on 06/25/2016. Readmitted 6/30/16 and restraint not reinstated.
2. An audit of all residents with active restraint will be conducted by 6/30/16 to determine if all consents, assessment and orders are accurately and fully completed. Those not in full compliance will be updated accordingly.
3. Re-education of the nursing staff will be undertaken in the following areas:
a) Device/Restraint assessment completion.
b) Obtaining of consent for restraint.
4. Audits of new admissions with Devices / restraint orders and inpatients with new Devices / restraint orders will be undertaken by the Unit Managers weekly for one month, then monthly for two months, then quarterly for two more quarters. The DON, or designee, will audit the process to ensure it is being completed. Any deviations will be forwarded to the QA committee for resolution.

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A review of Resident #30's clinical record was conducted on 06/29/2016 at 9:00 a.m. A nursing progress note dated "Late Entry 7/18/2015 23:33 (11:33 p.m.)" stated, "Note Text: Resident was found on the floor mat 07/18/15...Fall precaution measurements...remain in place. However due to multiple frequent fall (sic) and increased risk for injuries a Lap buddy was added to the precautionary measures..."

A "Device Assessment Effective Date: 07/19/201507:13 (7:13 a.m.)" included the following documentation: "A. Type of device 1. Assist bars...5. Concave mattress...17. Low bed with mats...B. Restraint identification...2. Device(s) are not considered to be restrictive..." Lap Buddy was not marked on the device list.

A "Restraint-Physical (Quarterly/Annual Evaluation)" was completed on 07/23/2015, 10/23/2015 and 04/23/2016. No restraint assessment was located in the clinical record for the month of January 2016.

According to documentation, Resident #30 was unable to remove the lap buddy.

The current POS (physician order set) dated June 01, 2016 through June 30, 2016 included the following order: "...lap buddy to be on while patient is in wheelchair every shift per protocol...Order Date 07/23/2015 Start Date 07/23/2015..."

Facility policy for Restraints, Effective Date 02/01/15 included the following documentation: "Policy: The Device Assessment will be completed to provide documentation of the

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needs, and risk factors involved in the use of a restraint or device used by the patient. Procedure: ...3. Restraints are applied only with a physician's order after assessment determines the medical symptom. The assessment is to be completed by a licensed nurse before initiation of any restraint or device. The assessment will be reviewed and revised quarterly, annually, and with any significant change. 4. A licensed nurse will complete the assessment with input from the Interdisciplinary Care Team, as applicable and entered on the Care Plan...6. A physician's order must be obtained for the restraint...8. Obtain consent for use of restraint."

The Administrator and DON (director of nursing) were interviewed regarding Resident #30's restraint during a meeting with survey team on 06/29/2016 at approximately 4:15 p.m. The Administrator stated, "Yes, a consent is needed for restraints. Under communication on the restraint evaluation is considered consent. We do not have a separate consent for the RP (responsible party) to sign." The Communication section included the following: "1. Date the Family/POA (power of attorney)/Decision Maker Notified of Decision 07/23/2015 2. Who was notified? (Name of RP) 3. How was the family/POA/decision maker notified? telephone 4. Who provided the communication? (Name RN {registered nurse}) 5. Comments: Resident's RP is highly supportive of this intervention..." No formal, signed consent or note referencing a consent signature would be obtained from the RP in the future was located in the clinical record.

Neither the Administrator or DON had any comment on why the Lap Buddy Restraint had been placed on Resident #30 on 07/18/2015

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F 221	Continued From page 4 before an assessment had been completed, a doctor's order had been obtained or a consent obtained. Nursing assessment and physician order were both obtained 07/23/2015. Resident #30's RP wasn't notified of the use of a restraint until 07/23/2015. No further information was received by the survey team prior to the exit conference on 06/30/2016.	F 221 i		
F 224 SS=D	483.13(c) PROHIBIT **MISTREATMENT/NEGLECT/MISAPPROPRIATN** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224!		8/1/16
	This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and family interview, the facility staff failed for one i of 34 residents in the survey sample (Resident# 34) to prevent the neglect and potential deterioration of the resident's physical condition. The factors leading to the finding of neglect include the following: a) Orders for the care of Resident# 34's leg wound were not obtained in a timely manner; b) Assessment, monitoring, and care of the resident's legs and leg wound was not provided by the facility's nursing staff; c) The resident's attending physician, who was also the Co-Medical Director, failed to exercise due diligence in addressing the non-compliance of the		F224 Cross Reference to 12VAC 5-371-220 (A) and (8) and (C) and (D) 1. Resident # 34 was transferred to the **ER and went home thereafter on** 6/30/2016 2. Residents with active wounds will be audited to assess the presence of treatment orders and completion thereof, and assessment of wound as per MFA policy and procedure. Any anomaly will be corrected immediately 3. Re-education will be completed with the Nursing Staff on the following: a) Skin/wound assessment on admission, weekly, and as needed	

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resident's family in the provision of nursing care.

The findings were:

Resident# 34 in the survey sample, a 90 year-old , female, was admitted to the facility on 6/12/16 with diagnoses that included cellulitis, lymphedema, generalized muscle weakness, cerebral infarction, edema, hypothyroidism, hypertension, vitamin deficiency, overactive bladder, and hyperlipidemia.

According to a Medicare 14-Day Minimum Data Set (MOS) with an Assessment Reference Date (ARD) of 6/26/16, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15.

a). Orders for the care of Resident # 34's leg wound were not obtained in a timely manner.

A thorough review of Resident# 34's Electronic Health Record (EHR) and paper clinical record failed to reveal any documentation that her legs and leg wound were assessed by the facility staff at the time of admission, or at any time prior to 6/30/16, when the legs and wound were first observed by the facility staff and the survey team.

Resident# 34's Electronic Medication Administration Record (E-MAR) included the following treatment order, dated 6/16/16, for the treatment of her leg wound, "Clean wound with N/S (Normal Saline), skin prep to peri-wound, primary dressing apply prisma AG, secondary dressing, piece of plain foam, (make sure to peel of [sic] plastic layer from back), then ABO pad if draining every day shift Mon (Monday, Wed

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b) Initiation of treatment order for wounds
c) Policy and procedure on patient refusal of treatmenVcare
4. Audits of new admissions will be completed by the DON/Unit Manager/Designee to ascertain that all admitted wounds are assessed and treatment orders initiated. The DON/Unit Manager/Designee will audit active wounds weekly x4 weeks, monthly x2 months, and quarterly x1 quarter to ensure the completion of weekly wound assessment and treatment. Anomaly will be rectified and forwarded to the QA for review and recommendation.

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(Wednesday), Fri (Friday) for wound care." The order for care of the leg wound was obtained four days after the resident was admitted.

During an interview at 12:30 p.m. on 6/30/16, the resident's daughter said, "To my knowledge, no one here has ever seen the wound." The resident's daughter went on to say that, "I told the nurses I would prefer if they didn't touch the (resident's) legs. I have no orders to take her to the wound clinic. I call and make an appointment : to go to the wound clinic."

At approximately 3:00 p.m. on 6/30/16, during an interview with the resident's attending physician, who also serves as the Co-Medical Director, the physician stated that he has never seen the resident's leg wound.

A thorough review of Resident # 34's EHR and paper clinical record confirmed there were no orders to seek treatment of the leg wound or lymphedema at the wound clinic.

b) Assessment monitoring, and care of the resident's legs and leg wound was not provided by the facility's nursing staff;

Resident# 34's Electronic Medication Administration Record (E-MAR) included the following order, dated 6/13/16, "Treatment - Lymphedema wraps every day shift lymphedema wraps to bilateral feet every day." The treatment order was signed off as having been performed daily from 6/13/16 through 6/30/16.

The E-MAR also included the following treatment order, dated 6/16/16 for the treatment of her leg wound, "Clean wound with N/S (Normal Saline),

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skin prep to peri-wound, primary dressing apply prisma AG, secondary dressing, piece of plain foam, (make sure to peel of [sic] plastic layer from back), then ABO pad if draining every day shift Mon (Monday, Wed (Wednesday), Fri (Friday) for wound care." Wound care was signed off on the E-MAR as having been performed on 6/17/16, 6/20/16, 6/22/16, 6/24/16, **6/27/16 and 6/29/16.**

During an interview at 12:30 p.m. on 6/30/16, the resident's daughter said she and her sister have done the wraps and wound care several times. "I told the nurses I would prefer if they don't touch the legs," the resident's daughter said.

Review of the facility's policy "General Wound Care/Dressing Changes" noted the following:

"POLICY: A licensed nurse will provide wound care/dressing change(s) as ordered by physician."

At 1:10 p.m. on 6/30/16, two of the staff members, who signed off the E-MAR as having performed the lymphedema wraps and wound care were interviewed. RN# 7 (Registered Nurse) said, "We don't do dressing changes, her daughter does them. We are not allowed to. We used to do it but we did not do it correctly."

RN # 8 stated, "We are just documenting that the dressings are intact, not that we are doing it. Sometimes I document in the Nurses Notes that the dressing is intact." RN# 8 went on to say that the Nurse Practitioner was made aware that staff is not doing dressing changes, but she (the Nurse Practitioner) did not write any new orders.

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F 224	Continued From page 8 c). The resident's attending physician, who was also the Co-Medical Director, failed to exercise due diligence in addressing the non-compliance of the resident's family in the provision of nursing care. At approximately 3:00 p.m. on 6/30/16, a telephone interview was conducted with the resident's attending physician, who also serves as the Co-Medical Director. The physician admitted e has never seen the resident's leg wound. He also said he did not know the resident's daughter had taken her to the wound clinic. The physician went on to say he was aware the resident and her family were non-compliant with the treatment orders for her lymphedema and leg wound. "We talked to the family multiple times," the physician said. "If the family is going against doctor's wishes for treatment, we just accept it." The physician inferred there was not much he could do to address the family's/resident's non-compliance. Asked if he had any notes of his conversations with the resident and her family, the physician said, "I don't recall."	F 224'		
F 271 SS=D	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and family interview, the facility staff failed, for	F 271.	F 271 Cross Reference to 12VAC 5-371-240 (C)	8/1/16

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one of 34 residents in the survey sample (Resident# 34) to ensure physician orders were obtained for the immediate care of the resident. Physician orders for the care of the resident's leg wound were not obtained until four days after the resident was admitted to the facility.

The findings were:

Resident# 34 in the survey sample, a 90 year-old female, was admitted to the facility on 6/12/16 with diagnoses that included cellulitis, lymphedema, generalized muscle weakness, cerebral infarction, edema, hypothyroidism, hypertension, vitamin deficiency, overactive bladder, and hyperlipidemia.

According to a Medicare 14-Day Minimum Data Set (MOS) with an Assessment Reference Date (ARD) of 6/26/16, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15.

Resident # 34's Electronic Medication Administration Record (E-MAR) included the following treatment order, dated 6/16/16, for the treatment of her leg wound, "Clean wound with N/S (Normal Saline), skin prep to peri-wound, primary dressing apply prisma AG, secondary dressing, piece of plain foam, (make sure to peel of [sic] plastic layer from back), then ABO pad if draining every day shift Mon [Monday], Wed [Wednesday], Fri [Friday] for wound care." The order for care of the leg wound was obtained four days after the resident was admitted.

At approximately 3:00 p.m. on 6/30/16, during an interview w!th the resident's attending physician,

F 271:

1. Resident # 34 was transferred to the ER and went home thereafter on **6/30/2016**
2. Current new admissions with a wound in the last 30 days will be reviewed to ascertain the initiation of treatment orders on the day of admission. **MD** and RP will be notified of any missing wound treatment order and initiate one as may ordered by the physician.
3. Re-education of Nursing Staff on the following:
   a. Initiation of treatment orders for all patients admitted with active wounds
4. DON/UM/Designee to audit new admissions to ascertain that those with active wounds have treatment orders; weekly x4 weeks, monthly x2 months, and quarterly x2 more quarters. Any anomaly will be corrected and then forwarded to the QA committee for further sustained resolution.

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F 271	Continued From page 10 who also serves as the Co-Medical Director, the physician stated that he has never seen the resident's leg wound. A thorough review of Resident # 34's EHR and paper clinical record confirmed there were no orders to seek treatment of the leg wound or lymphedema at the wound clinic.	F 271		
F 278 SS=D	483.20(g) - (j) ASSESSMENT **ACCURACY/COORDINATION/CERTIFIED** The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		8/1/16

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This REQUIREMENT is not met as evidenced by:

Based on clinical record review and staff interview, the facility staff failed for one of 34 residents in the survey sample (Resident# 20) to ensure a complete and accurate Minimum Data Set. The resident's eating status on the most recent Quarterly Minimum Data Set was incorrectly identified.

The findings were:

Resident# 20 in the survey sample, a 72 year-old male, was admitted to the facility on 10/2/15 with diagnoses that included ventricular fibrillation, mononeuropathy, generalized muscle weakness, hyperlipidemia, hypertension, anemia, enlarged prostate, arteriosclerotic heart disease, deep vein thrombosis, shortness of breath, depressive disorder, gastroesophageal reflux disease, and gastrostomy tube placement.

According to the most recent Quarterly Minimum Data Set **(MOS),** with an Assessment Reference Date of 5/10/16, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 14 out of 15.

Under Section G (Functional Status) of the Quarterly MDS, the resident was assessed as needing extensive assistance with one person physical assist for eating.

Resident# 20, whose dietary status was NPO (nothing by mouth), had a diet order for "Enteral feeding every 4 hours for Nutrition, Jevity 1.5 at

F 278 1 6/29/2016

F 278 Cross Reference to 12 VAC 5-371-250 (A)

1. Resident #201 ·s MDS, Section G for Assessment Reference Date of 5/10/2016, was corrected to reflect the feeding assistance status of the patient on

2. An audit of current feeding tube residents most recent Section G of the MOS will be reviewed to ensure accuracy. Any discrepancy will be rectified accordingly

3. Re-education of MOS registered nurses will be completed by 7/30/16 to include:

a. Accurate completion of Section G of the MOS with every ARD date for patient on feeding tube

4. Regional MOS Staff/Designee will review Section G of MOS assessment for feeding tube patients closed since last **audit. This will be completed on a weekly** basis for one month, then monthly for two months, then quarterly for two more quarters. Any deviation will be corrected and then forwarded to the QA committee for resolution.

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F278	Continued From page 12 237 ml (milliliters) bolus via G-tube (Gastrostomy) a (every) 4 hours." At 1:30 p.m. on 6/29/16, RN # 6 (Registered Nurse), the fourth floor MOS Coordinator, was asked about the resident's assessment of needing extensive assistance with one person physical assist for eating, when the resident was receiving all of his nutrition and fluids by way of a G-tube. After reviewing the Quarterly MOS, RN # 6 said, "It (the eating assessment) should be 4/2 (total dependence with one person physical assist). It is a mistake. It is my fault." The Resident Assessment Instrument Manual notes the following regarding a resident who receives nutrition and fluids by a feeding tube, "Code totally dependent in eating: only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure)." (Ref. CMS's RAI Version 3.0 Manual, page G-3, September 2010.)	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279)		'8/1/16

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The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to develop comprehensive care plans for three of 34 residents, Resident #7, Resident #2 and Resident #21.

1. Resident #7 was admitted to the facility on 06/09/2015 with bilateral AFO's (ankle foot orthosis). He was not care planned for the use of the devices.

2. Resident #2 was not care planned for activities.

3. Resident #21 was not care planned for activities.

Findings were:

1. Resident #7 was admitted to the facility on 06/15/2015. His diagnoses included but were not limited to: Type II diabetes mellitus, hypertension, Alzheimer's, dementia and GERO (gastro esophageal reflux disease).

F279 Cross Reference to 12 VAC 5-371-250 (F) and (G)
1. Resident #?f s ankle foot orthosis (AFO) was care planned on 7/19/2016. Resident # 2 activities care plan was completed on 6/29/2016. Resident# 21 Activities care plan was updated on 7/19/2016
2. A review of the care plan of current residents with AFOs will be completed. To ascertain its inclusion in the comprehensive plan of care. All current patients care plan will also be reviewed by Activities Staff to ascertain that they have individualized care plan for activities. Any incomplete care plan will be updated to reflect patient AFO and Activities accordingly
3. Re-education of nursing staff and Activities Staff will be completed to include:
a. Initiating care plan for an AFO
b. Initiating and maintaining an individualized activities care plan on patients

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The most recent MOS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 05/31/2016. Resident #7 was assessed as having a cognitive summary score of "09", indicating moderate impairment with his cognitive status.

On 06/28/2016 at approximately 2:30 p.m., Resident #7 was observed lying in bed with his eyes closed. Beside his bed were a pair of shoes with leg braces extending from each shoe.

The clinical record was reviewed. There were no orders on the POS (physician order sheet) for June for any type of lower extremity device. The i care plan was also reviewed. There were no entries on the care plan related to a need for lower extremity devices or their usage.

On 06/29/2016 at approximately 10:05 a.m., Resident #7 was observed sitting up in bed. He was jovial but pleasantly confused. He stated that he had been at the facility "about a week...I'll be going back soon." A pair of shoes with splints protruding from each were again observed at the bedside. Resident #7 was asked about the splints protruding from his shoes. He reached down beside the bed and picked up one of the splints. This surveyor could then observe that the splints were AFO splints. The splint was made of hard white plastic material and was in the shape of the resident's lower leg and foot. He stated "This thing? I bought my shoes like this." Resident #7 was asked what the splint was for. He stated, "I don't know, they came with the shoes. Do you like them?"

This surveyor spoke with the ADON (assistant director of nursing) at approximately 10:15 a.m.

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4. The DON or designee, will audit the care plan of identified patients with AFOs to ascertain inclusion in the comprehensive plan of care weekly x2 weeks, monthly x1, and then quarterly x1 quarter. Activities Staff will audit 10% of current patients care plan weekly for one month, then monthly for two months, and then quarterly for two more quarters to ascertain the presence of individualized activities care plan. Any deviations will be forwarded to the QA committee to ensure compliance.

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She was asked if she knew why Resident #7 had splints/ AFO's in his shoes. She stated that she did not know that he had splints. She then asked RN (registered nurse) #4 if he knew anything about the splints. He shook his head side to side, got up and left the nurse's station. The ADON was asked to look at the care plan and the POS with this surveyor. She was asked if she saw any information regarding the splints/AFO's. She stated, "No." The ADON was asked if she thought the splints/AFO's should be on the POS and/or the care plan. She stated, "Yes, it should be on the care plan."

The administrator, the DON (director of nursing) and the corporate nurse consultant were notified of the above information during a meeting on 06/29/2016. The administrator stated that therapy had evaluated Resident #7 that day (6/29/2016) to determine the need for the splints. He stated the splints had come in with the resident at the time of admission. He was not assessed at that time but had been evaluated by PT (Physical Therapy) that day (6/29/2016) and it was determined that the splints/AFO's were appropriate for the resident's usage. The administrator and the corporate nurse consultant stated that the splints were considered to be "Devices and a physician's order is not needed for devices...but they should be on the plan of care."

No further information was obtained prior to the exit conference on 06/30/2016.

2. Resident #2 had no individualized care plan

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developed regarding recreational activities.

Resident #2 was admitted to the facility on 12/19/13 with diagnoses that included atrial fibrillation, hypertension, major depressive disorder, heart failure, dementia with behaviors, mood disorder, insomnia, gastroesophageal reflux disease and anxiety. The minimum data set (MOS) dated 6/13/16 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's clinical record was reviewed on 6/28/16. The annual MOS dated 10/20/15 listed activities as a triggered assessment area requiring the development of a care plan. This MOS assessed the resident's preferences for activities as music, books, pets, group activities and religion.

The resident's care plan (revised 6/16/16) listed as a focus area, "The resident has little or no activity involvement." The activity care plan goal stated the resident would express satisfaction with activities and level of involvement. The care plan interventions made no reference to the resident's assessed preferences and included only generalized interventions. The care plan interventions listed included: Modify daily schedule to accommodate activity participation; Monitor impact of medical problems; Remind resident that she can leave activities at any time; Resident needs a variety of activity types and locations to maintain interests; Needs assistance to activity functions. The plan did not include interventions to increase the resident's activity participation.

On 6/29/16 at 10:20 a.m. the activity director was interviewed about Resident #2's plan of care.

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The activity director stated the resident liked and attended cooking groups, exercise groups and music activities. The activity director stated the resident did not speak English but non-verbally indicated her pleasure or displeasure with activities. Regarding the care plan, the activity director stated the individualized interventions related to her preferences "were not spelled out." The activity director stated the care plan could be more detailed regarding the resident's actual participation, preferences and ways to increase participation.

These findings were reviewed with the administrator, director of nursing and nurse consultant during a meeting on 6/29/15 at 4:15 p.m.

3. For Resident# 21, the facility staff failed to develop a plan of care to address the resident's specific activity preferences.

Resident# 21 in the survey sample, an 88 year-old male, was admitted to the facility on 2/10/16 with diagnoses that included bilateral pneumonia, mononeuropathy, hypertension, contractures, dementia, dysphagia, depressive disorder, seizures, and PEG (Percutaneous Endoscopic Gastrostomy) tube placement. According to the most recent Quarterly MOS, with an ARD of 6/21/16, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 00 out of 15.

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	F 279 Continued From page 18 Under Section F (Preferences for Customary Routine and Activities), at Item F0800 (Staff Assessment of Daily and Activity Preferences), the staff indicated the resident had a preference for the following activities; listening to music, keeping up with the news, doing things with groups of people, and participating in favorite activities. Review of Resident# 21's care plan revealed the following problem in the area of Activities, "Resident is dependent on staff for meeting emotional, physical, and social needs r/t (related to) physical limitations, cognitive deficits." The goal for the problem was, "Resident will maintain involvement in cognitive stimulation such as TV through review date." The approach to the stated problem was, "Resident's preferred activities are: TV and being with others." Resident # 21's care plan did not include his activity preferences of listening to music, keeping up with the news, and participating in favorite activities.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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	F 280		8/1/16

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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 staff interview and clinical record review, facility staff failed to review and revise comprehensive care plans (CCP) for five of 34 residents in the survey sample, Residents #30, #5, #11, #15 and #19.

1. Facility staff failed to update Resident #30's CCP for restorative nursing and use of a lap buddy restraint.

2. Facility staff failed to update Resident #5's CCP for oxygen and activities.

3. Resident #11's care plan was not revised to include problems, goals and/or interventions regarding supervision during smoking and safety related to exit seeking behavior.

4. Resident #15's care plan for communication was not updated.

5. The facility staff failed to review and revise Resident# 19's comprehensive care plan to include interventions for safe smoking due to seizure activity.

F 2801

F280 Cross Reference to 12 VAC 5-371-210 (A) (3)

1. Resident #30 was at the hospital on 6/23-30/2016 and is no longer on restorative program, but rehabilitation therapy. Resident #5 care plan was updated to accurately reflect patient's oxygen therapy on 6/29/2016 and activities on 6/29/2016. Resident #11 care plan was revised to reflect patient's supervision during smoking and safety on 6/29/2016. Resident # 15 care plan for communication was updated on 6/28/2016. Resident# 19 transferred to the hospital on 7/10/2016 and went home thereafter.

2. A review of the care plan of current residents who smoke and requires supervision were reviewed to ensure the inclusion of smoking supervision. A review of all current patients care plan on oxygen therapy, communication impairment, restorative nursing, and restraints will be completed to ensure their inclusion in the comprehensive plan of care. Any anomaly will be updated

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Findings included:

1. Facility staff failed to update Resident #30's CCP for restorative nursing and use of a lap buddy restraint.

Resident #30 was admitted to the facility on 03/14/2015 with diagnoses including, but not limited to: Fractured Right Humerus, Osteoarthritis, Joint Pain, Alzheimer's Disease, Dysphagia, Depression, Dementia with Behaviors and a History of Falls.

The most recent MOS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/24/2016. Resident #30 was assessed as severely impaired in her cognitive status with a total cognitive score of four out of 15.

A review of Resident #30's clinical record was conducted on 06/29/2016 at 9:00 a.m. The CCP for Resident #30 contained the following documentation: Focus: Restorative-Ambulation/ROM (range of motion) "Created on: 06/30/2015 Revision on: 07/01/2015" The "Interventions" section of the care plan for the above "Focus" area was completely blank.

Focus area for "Falls" stated, "The resident is at increased risk for falls, uses lap buddy...Created on: 03/14/2015 Revision on: 06/03/2016...Interventions: ...Device: Assist bars to enhance bed mobility. Low bed and floor mats to minimize fall related injuries. Perimeter mattress to assist in defining bed edges..." No specific interventions related to use of a lap buddy restraint were included.

F 280

immediately

3. Re-education on updating/revision of care plans will be completed to include:
a. Updating of care plans for patients requiring smoking supervision
b. Timeliness of care plan updating with every change that affects other interventions on the care plan
c. Revision of care plan for patients on oxygen therapy
d. Revision of care plan for patient with communication difficulty.
4. The DON/Designee will audit weekly x2 weeks, monthly x2 months, and quarterly x1 of all care plans for residents on supervised smoking, oxygen therapy, on restraint, and with communication difficulty ensure accuracy and completeness. Unit Managers will conduct ongoing auditing of all patients on supervised smoking to ensure accuracy and correctness of care plan interventions weekly for one month, then monthly for two months, then quarterly for two more quarters. Any deviations will be forwarded to the QA committee for resolution.

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Focus area for "Physical Restraints" stated, "The resident uses physical restraints lap buddy r/t (related to) multiple falls with injuries...Created on: 07/23/2015 Revision on: 09/23/2015...Interventions: Discuss and record with the resident/family/caregivers, the risks and benefits of the restraint, when the restraints should/will be applied, routines while restrained and any concerns or issues regarding restraint use. Created on: 07/23/2015 Ensure The resident is positioned correctly with proper body alignment while restrained. Created on: 07/23/2015." No specific interventions for restraint use were included in CCP. No updated interventions had been added since the lap buddy was first care planned on 07/23/2015.

The Administrator, DON (director of nursing) and Corporate RD (registered dietitian), Administration #4 were interviewed regarding care plan updates on 06/29/2016 at approximately 3:10 p.m. The DON stated; "Nursing or anyone can update as needed." Administration #4 stated, "Anybody can update. It is not interdisciplinary specific." The DON then stated, "It should be updated with any MOS assessments and any other time orders change the plan of care."

No further information was received by the survey team prior to the exit conference on 06/30/2016.

2. Facility staff failed to update Resident #S's CCP for oxygen and activities.

The Findings Include:

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Resident #5 was originally admitted to the facility on 07/06/2012 and readmitted on 05/31/2016 with: diagnoses including, but not limited to: Hepatitis-C, Parkinson's Disease, Seizures, Encephalopathy, Sepsis, Dysphagia, Psychosis, Anxiety, Hypertension, Schizophrenia, Protein-Calorie Malnutrition and Dehydration.

The most recent MOS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 05/19/2016. Resident #5 was assessed as severely impaired in his cognitive skills with a total cognitive score of three out of 15.

Review of Resident #5's clinical record was conducted on 06/28/2016 at 9:00 a.m. Included in the current POS (physician order sheet) dated 06/01/2016 through 06/30/2016 was an order for oxygen that stated, "Oxygen Therapy - Oxygen at 4L liters per minute via nasal cannula every shift...Order Date: 06/23/2016 Start Date: '06/24/2016."

Subsequent review of the CCP (comprehensive care plan) included the following documentation: Focus - "Oxygen Therapy...Created on: 04/14/2016 Revision on: 06/23/2016...Interventions...Oxygen Settings: 02 (oxygen) via: nasal prongs/mask)@ (at) 2L (liters) cont..(continuous) Humidified. Created on: 06/23/2016." However, Resident #5's most recent 02 order was for 4L/min/nc (4 liters per minute via nasal cannula). Resident #5's 02 settings were observed several times during the survey and were always observed at 4L/min/nc.

Focus area for "Activity" included the following: "The resident has little or no activity involvement.

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Created on: 06/09/2015 Revision on: 05/31/2016...Interventions: Pt (patient) will watch TV as desired, and visit with brother." No other interventions were included in this resident's activities care plan. On 06/29/2016 at 10:30 a.m., the Activities Director (Other #2) was interviewed regarding Resident #5's CCP. The Activities Director stated, "When he first came in he would attend some activities, but stayed back from the group. He watched mostly, didn't really participate. His health has severely declined the past few months. He watches TV and visits with his brother. Doesn't really leave his room. I will talk to [Other #4- Activities assistant] and see if she has any other interaction with him."

At approximately 2:00 p.m. on 06/29/2016, Other #2 entered the conference room and stated the following: "I tried to talk to [Resident #5] today. He is out of it. Resident's roommate stated he doesn't even talk to his brother when he visits now. I spoke with [Other #4], she stated she would go to his room in the past and he basically would stare at her and not speak. She would just leave. If he rallies and gets more alert we will certainly reassess him."

Focus area of "Physical Mobility" stated the following: "The resident has limited physical mobility...Interventions: Ambulation: The resident is able to: with the assistance of staff. resident (sic) is unable to ambulate without staff assistance. Locomotion: The resident is able to: wheel self on the unit. Activities: .Invite The (sic) resident to activity programs that encourage physical activity, physical mobility, such as exercise group, walking activities to promote mobility..." All created on: 07/25/2014 revision on: 05/31/2016. Resident #5 was admitted to the

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hospital on 04/27/2016 through 05/12/2016 and again on 05/24/2016 through 05/31/2016. It was well documented in the clinical record his rapid decline in physical condition. Resident #5 is unable to perform any of the above listed interventions.

The DON (director of nursing) and Corporate RD (registered dietitian), Administration #4 were interviewed regarding care plan updates on 04/29/2016 at approximately 3:10 p.m. The DON i stated, "Nursing or anyone can update as needed." Administration #4 stated, "Anybody can . update. It is not interdisciplinary specific."

The Administrator and Nursing Consultant were informed of the above information during a meeting with the survey team on 04/29/2016 at approximately 4:15 p.m. The Administrator stated, "Obviously we have some work to do on updating care plans."

No further information was received by the survey team prior to the exit conference on 06/30/2016.

. 3. Resident #11's care plan was not revised to include interventions regarding supervision during smoking and safety related to exit seeking behavior. The resident exhibited exit seeking behavior and was assessed with a need for supervised smoking in response to a change in visitation frequency by his guardian. The resident's care plan was not revised with interventions to ensure a safe smoking environment, use of an applied Wanderguard device or supervision for outside safety.

Resident #11 was admitted to the facility on

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3/30/15 with a re-admission on 4/24/16. Diagnoses for Resident #11 included traumatic brain injury, epilepsy, cerebrovascular disease, aphasia, anorexia, anxiety, major depressive disorder, neuropathy and anemia. The minimum data set (MOS) dated 6/8/16 assessed Resident #11 with severely impaired cognitive skills and functional limitation in range of motion of his upper and lower extremities on one side.

On 6/28/16 at 10:40 a.m. an interview about quality of life in the facility was conducted with the resident's guardian. The guardian stated she routinely visited and spent time with Resident #11 daily but was unable to visit during several weeks in May (2016) due to illness. The guardian stated she was "just coming back" to the facility after being sick. The guardian stated when she was unable to visit in May 2016, aWanderguard device was placed on Resident #11's wheelchair causing the door to alarm when Resident #11 attempted to go outside. The guardian stated she accompanied the resident outside during her visits and was concerned that staff members did not take Resident #11 outside when she was unable to visit. The guardian stated the resident routinely smoked in the designated smoking area and she did not understand why the resident had the Wanderguard.

Resident #11's clinical record was reviewed on 6/28/16. The clinical record documented the following about smoking.

9/11/15 - "Patient is non compliance with smoking. Writer spoke to patient's guardian...regarding the medical disadvantage of smoking especially his head injury. Guardian stated that her grandson has been smoking

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through out his life and no body will stop him smoking..." (sic)

9/14/15 - "...DON [director of nursing] and writer explained the adverse effects of smoking and wound healing to guardian. The guardian said he does not matter the medical problems patient may have, he is fine for him to smoke...So she (guardian] authorized two alert and oriented residents to assist patient with smoking when staff are not around. She will provide cigarettes..." (sic)

1/18/16 - "At around 1930 [7:30 p.m.] resident insisted to go out by himself to smoke. Writer explain to resident he cant [can't] go out by himself and need an escort. Resident got upset and started striking the walls, and his head. Resident family was notified. Resident [Guardian]...stated 'resident can go out and smoke by himself with no escort needed'."

A smoking assessment dated 3/29/16 listed the resident was safe to smoke without supervision or safety devices. A "Smoking - Safety Screen" for Resident #11 dated 3/29/16 listed the resident had cognitive loss, had dexterity problems, smoked 2 to 5 cigarettes per day and liked to smoke in the morning, afternoon and evening. This assessment stated Resident #11 was able to light his cigarettes, required no apron, no cigarette holder, no supervision or one to one assistance for smoking. In addition, this assessment documented the resident was safe to keep his own lighter and cigarettes. This assessment documented, "At this time resident is deemed a safe smoker and so will not need no protective equipment for his safety or other residents' safety..." (sic)

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- Resident #11's care plan (revised 5/27/16) listed the resident was a smoker. On 5/25/16 the care plan was updated requiring supervision with smoking. The care plan stated, "Resident is a smoker." The care plan goal regarding smoking, stated, "Resident will not smoke without supervision through the review date." Care plan interventions for smoking stated, "Instruct resident about smoking risks and hazards and about smoking cessation aids that are available...Instruct resident about the facility policy on smoking: locations, times, safety concerns...Notify charge nurse immediately if it is suspected resident has violated facility smoking policy...Observe clothing and skin for signs of cigarette burns...Resident requires SUPERVISION while smoking."

The clinical record documented a physician's order dated 6/15/16 for a Wanderguard device secured to the right side of Resident #11's wheelchair due to exit seeking behavior.

Resident #11's care plan included no interventions regarding who was responsible to supervise the resident during smoking. The care plan made no mention of the resident's use of the Wanderguard device or of any problems or safety concerns about the resident going outside unsupervised. There were no revisions to the care plan regarding the resident's documented non-compliance with smoking supervision or exit seeking behavior. The care plan documented the resident had poor safety awareness, impaired cognitive function due to traumatic brain injury, impulsive behavior, adverse behaviors that included scratching and removing wound dressings, cursing, hitting and kicking staff and

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refusal of care. The care plan also documented the resident had communication problems due to speech impairment from a stroke.

Resident #11's clinical record documented the resident had a history of falls, was non-compliant with care and was at times combative with staff and was self-injurious. Nursing notes for May and I through 6/27/16 documented the following.

5/9/16 - "Resident was found on the floor mat in his room...Resident had an actual fall and at risk, for further falls r/t [due to] poor safety awareness, confusion and impulsive behavior secondary to TBI [traumatic brain injury]"

5/12/16 - "...Resident has history of falls. Resident has contracture of his left arm. Resident is unable to bend his left leg. Resident has history of accident and sustained head injury. Resident has history of seizures. Resident is **unable to talk but utters sounds when he needs** assistance...Resident exhibits adverse behavioral symptoms namely: Intensely scratching and removing dressing on scalp wound, cursing, hitting, kicking staff, and refusing to be changed..."

5/15/16 - "...While in the dining room resident was observed trying to hit the sister..."

5/16/16 - "Resident was observed trying to go [to] the bathroom on his own. Resident lost his balance and fell on the floor..."

5/22/15 - "Resident behavior is very alarming this morning. As care team was attempting to provide care to resident he started kicking and swearing curse words as well as trying to punch staff. We

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F 280	Continued From page 29 attempted again to get resident cleaned up from urine accident and he ripped the diaper off and slung it at staff. We immediately left the room before anyone got hurt..." 5/23/16 - "...Resident easily becomes angry. At first he did not want staff to remove his shoes. Resident started to hit his head..." 5/26/16 - "During review period resident exhibited increased agitation and aggression as evidenced by hitting and kicking staff and hitting himself in the head..." 5/27/16- "...Resident is non-compliant with care. Resident was incontinent of urine this am [morning] and refused to be changed..." 5/31/16 - "...Resident was not observed but he states he was pointing at his breakfast tray that was left in his room so it seems like he was trying to reach his tray to eat breakfast in the process lost his balance..." 6/14/16- "...Resident is very non compliant with keeping dressing on. Removes dressing and picks on wound..." 6/16/16 - "...Resident continues to remove dressing on scalp and picking on wound..." 6/17/16 - "...Resident continues to remove dressing on scalp and picking on wound..." On 6/28/16 at 1:45 p.m. the facility's activity director was interviewed about Resident #11. The activity director stated Resident #11 routinely went outside and smoked in the designated smoking area without supervision. The activity	F 280		

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F 280	Continued From page 30 director stated Resident #11 went outside and "there was not always a staff person assigned." The activity director stated the resident liked to sit on the walk near the front entrance and spend time in the designated smoking area. The activity director stated she felt Resident #11's going outside and smoking unsupervised was not safe. The activity director stated the entire smoking area was unsafe because there was no routine supervision of residents smoking. The activity director stated Resident #11 had a Wanderguard placed when his family member was unable to routinely visit and the resident had increasing behaviors of leaving the facility. The activity director stated with the Wanderguard the front entrance door alarmed when Resident #11 approached to exit but that the front desk receptionist "deactivated" the alarm and let Resident #11 outside. The activity director stated if the resident went out of the front door to the left toward the main highway, the front desk receptionist went after the resident and re-directed him. The activity director stated the resident was allowed to go out the door to the right toward the smoking area unsupervised. The activity director stated Resident #11 was usually accompanied to the smoking area by Resident #19. The activity director stated concerning going outside with activity staff, "I'm not taking him [Resident #11] out." The activity director stated when volunteers were available some residents were accompanied outside but Resident #11 had not been included in outside activities. The activity director stated she felt the entire smoking area was unsafe because there was no scheduled supervision of the area or the residents.	F 280		

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CHERRYDALE HEALTH AND REHABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207

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On 6/28/16 at 2:05 p.m. the designated smoking was observed. The smoking area was located under an awning at the one end of the building accessible from the main parking lot. The smoking area was not visible from the front lobby or reception desk. The area was accessible from the front sidewalk area, front parking lot and a side entrance into the building. There were four residents in the smoking area at the time of this observation. Two of the four residents were actively smoking. One resident was sitting on a bench with a cigarette lighter in her hand. There were no staff members present and no protective aprons in use.

On 6/28/16 at 2:15 p.m. the licensed practical nurse (LPN #3) that routinely cared for Resident #11 and completed the smoking assessment dated 3/29/16 was interviewed. LPN #3 stated the assessment on 3/29/16 listed the resident as safe to smoke without supervision. When asked how the resident was assessed as safe to smoke without supervision when he had severely impaired cognitive skills, LPN #3 stated the guardian usually went with the resident outside. LPN #3 stated the resident had developed exit seeking behaviors during the last several weeks when his guardian was sick and no longer visited daily. LPN #3 stated the Wanderguard was placed on the resident's wheelchair because it was unsafe for the resident to go out toward the garden and highway unsupervised. LPN #3 stated, "We [staff] were afraid he was going farther." LPN #3 stated prior to the guardian's illness, the resident had been going outside frequently with the guardian, his cousins and sometimes a therapy aide. LPN #3 stated when the guardian was unable to visit each day the resident made increased attempts to go out

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alone. When asked how the resident went out of the facility with a Wanderguard device in use, LPN #3 stated the alarm was turned off. When asked how she was sure the resident was supervised when he went out to smoke, LPN #3 had no response. LPN #3 stated the nurses and unit manager were responsible for updating care plans.

On 6/28/16 at 2:30 p.m. the registered nurse unit manager (RN #5) was interviewed about Resident #11 smoking and going outside without supervision. RN #5 stated Resident #11 was "not supposed to be by himself' when smoking. RN #5 stated prior to guardian's illness, the guardian routinely went out with the resident to smoke. RN #5 stated when the guardian became sick and did not visit each day Resident #11 became more agitated and exit seeking. RN #5 stated the Wanderguard device was placed on the resident's wheelchair to prevent him from leaving the facility without staff knowledge. RN #5 stated the receptionist called him from the lobby when Resident #11 was attempting to leave the building and he would go or send staff to redirect or supervise the resident.

When asked if he was aware that the receptionist was turning off the Wanderguard alarm and allowing Resident #11 to go outside and smoke unsupervised, RN #5 stated, "No." When asked about the assessment on 3/29/16 that listed the resident as safe to smoke without supervision, RN #5 stated that assessment was wrong. RN #5 stated the resident had severely impaired cognitive abilities due to his brain injury and required supervision. RN #5 stated the current care plan was correct and the resident required supervision to smoke.

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On 6/28/16 at 2:40 p.m. the front desk receptionist was interviewed about Resident #11. The receptionist stated that Resident #11 sometimes went out of the facility with Resident #19. When asked how Resident #11 went out of the facility with the Wanderguard device in place, the receptionist stated she "deactivated" the alarm by swiping her card so Resident #11 could go outside. The receptionist stated she sometimes let Resident #11 sit out on the front walk. The receptionist stated, "I eyeball him from in here." The receptionist stated if she saw Resident #11 going left toward the highway she would get him or alert other staff members. The receptionist stated sometimes a staff member went with Resident #11 outside and other times the resident went out with Resident #19. When asked if Resident #11 went to the smoking area supervised, the receptionist stated, "Not always." The receptionist stated she deactivated the Wanderguard alarm and allowed Resident #11 to go out of the front door toward the smoking area. The receptionist stated Resident #19 usually accompanied Resident #11 to smoke. The receptionist stated the smoking area was not visible from her desk but that Resident #11 was usually with Resident #19 when he went to smoke.

On 6/28/16 at 3:30 p.m. the administrator, nurse consultant and director of nursing (DON) were interviewed about Resident #11 smoking unsupervised when his plan of care required supervision. The administrator stated when the resident was first admitted to the facility the guardian did not want the resident to smoke. The administrator stated the resident enjoyed going outside and wanted to be with other young

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F 280	Continued From page 34 smokers so a plan was initiated regarding smoking. The nurse consultant stated when the resident originally started smoking he was able to smoke safely. The nurse consultant stated recently the resident had increased behaviors and was considered a "possible danger." The nurse consultant stated Resident #11 had declined in condition and there was "maybe a need to supervise, to watch him from a distance." The DON stated the Wanderguard was added because Resident #11 was trying to go outside alone. The DON stated sometimes the resident would sit safely near the front entrance and sometimes he attempted to go toward the street. The -DON stated the front desk receptionist watched the resident when he went outside. When asked how the resident was supervised when smoking as the smoking area was not visible from the lobby or front desk, the administrator stated the resident's guardian was "ok" with him going outside and smoking unsupervised. On 6/29/16 at 1:10 p.m. RN #5 unit manager was interviewed again about Resident #11's care plan. RN #5 stated the resident's care plan should have been updated when he was assessed with changes in behavior. RN #5 stated care plans were reviewed at least quarterly and updated as needed by nurses. RN #5 stated the resident had increased exit seeking behavior that started when the guardian was unable to visit each day. RN #5 stated the guardian had "just come back this week" to visit the resident after being absent several week in May 2016. RN #5 stated the care plan should have reflected the changes in behaviors, the Wanderguard use and the related safety concerns.	F 280		

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On 6/29/16 at 4:40 p.m. the administrator was interviewed about Resident #11 smoking and going outside unsupervised. The administrator stated it was "most appropriate" for Resident #11 to be a supervised smoker but the guardian wanted the resident to be allowed to smoke. When asked about the resident's care plan that made no mention of interventions allowing the resident to smoke unsupervised or the use of the Wanderguard, the administrator stated the care plan needed to be updated. The administrator stated the Wanderguard alarm was to alert staff the resident was going outside. The administrator stated when Resident #11 went outside the front desk receptionist alerted staff if he was going toward the main highway. The administrator stated, "The front desk person is monitoring that [going outside]." The administrator stated the resident was allowed to smoke unsupervised because they were trying to maximize the resident's freedom and honor the guardian's wishes for the resident to go outside and smoke independently. When asked why the plan of care made no mention of the Wanderguard, unsupervised smoking or the receptionist's monitoring of the resident, the administrator stated, "When the ID [interdisciplinary] team figures out how to handle this we need to update the care plan." Concerning the unsupervised smoking, the administrator stated, "We want to honor the guardian's decision to willingly accept the risks [of unsupervised smoking]." The administrator stated there were no designated smoking times in the facility and residents were allowed to smoke in the smoking area from 8:00 a.m. until 10:00 p.m. each day.

The facility's policy titled Patient Smoking

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(effective 2/1/15) documented, "A patient may smoke in designated smoking area that may be established on the grounds of the Center: a. if the patient has been assessed by the interdisciplinary team, and b. it has been determined through the Safe Smoking Assessment that it is safe for the patient to smoke...any patient who wishes to smoke will be evaluated (see Safe Smoking Assessment) by the Interdisciplinary Team upon admission to determine safety and ability to handle smoking material. The patient must also sign the MFA Patient Smoking Acknowledgement form which is to be maintained in the patient's medical record. If supervision is deemed necessary the patient will be supervised by staff or other appropriate person (i.e., family member) and with any safety devices needed (i.e., smoking! apron)...A smoking schedule will be created for patients requiring supervision. All instruments that cause a spark or a flame (igniting products) will be kept in a locked location...Failure to comply with the use of any smoking and/or igniting products may result in the initiation of the i discharge process."

Resident #11's care plan (revised 5/27/16) made no mention of any **exit** seeking behaviors or increased agitation related to the change in visitation frequency by the guardian. Resident #11's nursing notes during May 2016 made no mention of the resident's exit seeking behavior, use of the Wanderguard device, or any supervision plan regarding the resident's smoking. Resident #11's care plan was revised on 5/25/16 with the requirement for supervised smoking but the plan included no interventions to ensure supervision. There were no care plan revisions regarding the resident's non-compliance with supervised smoking.

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These findings were reviewed with the administrator, director of nursing and nurse consultant on 6/29/16 at 4:15 p.m.

4. Resident #15 care plan for communication was not updated.

Resident #15 was admitted to the facility on 4/7/16 with a readmission on 6/24/16 with diagnoses including, but not limited to: Gout, hypertension, osteoarthritis, urine retention, anxiety, personality disorder, obesity, and soft pallet cancer.

The most recent MOS (minimum data set) was a : 14 day assessment with an ARD (assessment reference date) of 4/21/16. Resident #15 was assessed as being cognitively intact with a total cognitive score of 13 out of 15.

Resident #15's electronic record was reviewed on 6/28/16 and evidenced, via care plan, that Resident #15 had communication problem due to soft pallet cancer. Interventions for communication included, "Anticipate and meet needs."[...] and "Be conscious of residents position when in groups, activities, dining room to promote proper communication with others. Created on: 04/18/2016 Revision on: 06/24/16."

On 6/28/16 at 2:00 p.m. Resident #15 was observed lying in bed. This surveyor knocked the door and entered the room. This surveyor began talking to Resident #15 about the Resident's catheter care and realized Resident #15 did not communicate well when talking in sentences, but could verbalize "yes, no" and shake and nod his

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F 280,

head.

At this time 2 certified nursing assistance (CNA's) came into the room along with a registered nurse (RN). This surveyor continued to converse with Resident #15 about care at the facility and Resident #15 would respond, but was not able to be understood by the surveyor.

While the staff was in the room with Resident #15 this surveyor asked the two CNA's and the RN what Resident #15 was saying. The RN (identified as RN #7 asked the Resident what he said, Resident #15 repeated what he was saying several times and seemed to become somewhat frustrated.

Neither the staff in the room or this surveyor was able to understand what Resident #15 was trying to verbalize. This surveyor asked the three staff members if Resident #15 had any type of communication device. RN #7 verbalized that Resident #15 wouldn't use a communication device.

On 6/28/16 at 4:00 p.m. the above finding was brought to the attention of the administrator and director of nursing (DON).

On 6/29/16 at 8:00 a.m. this surveyor was presented with a care plan to include a communication board.

No further information was presented prior to exit conference on 6/30/16.

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5. The facility staff failed to review and revise Resident# 19's comprehensive care plan (CCP) to include interventions for safe smoking. The CCP was not updated to reflect the resident's unsafe behaviors and non-compliance with the smoking policy of the facility.

Resident# 19 was initially admitted to the facility 4/18/15 with a readmission date of 5/25/16. Diagnoses for Resident# 19 included, but were not limited to: epileptic seizures, COPD, GERO, depression, difficulty walking, asthma, schizoaffective disorder-bipolar type, irritable bowel syndrome, and unspecified psychosis.

The most recent MOS (minimum data set) was a quarterly review dated 6/1/16 and had the resident as being cognitively intact with a total summary score of 15 out of 15.

The electronic medical record (EMR) was reviewed 6/29/16 at 9:00 a.m. Nursing notes documented the following:

4/8/16 06:28(6:28 a.m.) "Writer reported to work at 05:45 (5:45 a.m.) and met [name of resident] sitting outside the main entrance smoking. Writer witness [sic] same situation Tuesday 4/5/16 and resident was educated to wait until secretary at lobby to activate door to 'open' so he can be seen by staff. Resident also educated on risk of having a seizure when he is alone with no staff member around. Writer asked resident how he got out and he stated he wait at the lobby for phlebotomist or delivery people coming in and out and also leave and enter. Writer again educated resident about his frequent seizure activity and risk of having seizure with no staff around due to his noncompliance with the facility smoking rules.

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F 280	Continued From page 40 He verbalized understanding of the risk." 4/19/1615:46 (3:46 p.m.)- "....writer and staffs [sic] responded to resident having seizure while smoking downstairs...." 4/19/16 18:30 (6:30 p.m.)- "DON [director of nursing] and charge nurse met with resident to discuss resident's noncompliance with leaving the unit unsupervised due to frequent recurrent seizure activity and associated risks.....Resident has been educated on the disease process, safety, that his noncompliance is placing him at a very high risk for injuries that may even result in death.....has chosen not to understand or comply. NP visiting facility was notified." The CCP was then reviewed. Under "Focus" was documented "Resident is a smoker" The date the CCP was created was dated 5/21/15 with a revised date of 5/23/16. Under "Goals" was documented "The resident will not suffer injury from unsafe smoking practices through the next review." Under "Interventions" was documented "Instruct resident about smoking hazards and about smoking cessation. Instruct resident about the facility policy on smoking: locations, times, safety concerns. Notify charge nurse immediately if it is suspected resident has violated smoking policy. The resident can smoke UNSUPERVISED [sic]. The resident is able to safely light own cigarette and may keep lighter at bedside." There were no additional interventions about the meetings with the resident in regards to needing supervision due to seizure activity, or his behavior of getting out of the facility by waiting for the door to be opened by ancillary people coming in and out of the facility.	F 2801		

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	During a meeting with facility staff 6/29/16 beginning at 4:25 p.m., the administrator and DON were asked about the meeting with the resident, and the documentation in the nurses' notes concerning the resident's noncompliance with the smoking rules, and the behaviors of exiting the facility unsupervised. The administrator stated that cognitive residents could smoke unsupervised from 8:00 a.m. until 10:00 p.m. There were no "set" times for residents to smoke. The administrator and DON were again asked if the CCP should have been updated to include safety interventions and supervision as discussed with the resident. The administrator stated "If the IDT [interdisciplinary team) had felt it was necessary...." The DON did not comment. An updated CCP dated 6/29/16 was presented to this surveyor prior to the exit conference. The updated CCP included additional interventions for "Resident will be provided smoking apron related to potential of seizing during smoking." Resident will smoke under supervision at around 9 am, 1 pm, 6:15 pm, and 8:30 pm." "Smoking supplies (cigarette, lighter/match) will be stored in a locked location and given to resident at smoking times and collected back after smoking."			
	F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=E PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review,	F 281 !	F281 Cross Reference to 12 VAC	8/1/16

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review of facility policy, family interview, and staff interview, the facility staff failed for four of 34 residents in the survey sample (Residents# 20, 21, 22 and 34) to follow accepted standards of nursing practice.

1. For Resident# 34, facility staff failed to perform a nursing assessment of a leg wound at the time of admission, and documented dressing changes as being performed that were not being done.

2. For Resident# 20, staff failed to check feeding tube placement prior to the administration of medications and tube feeding.

3. For Resident# 21, facility staff failed to correctly check the placement of a feeding tube prior to the administration of medications and tube feeding, and signed as having administered a medication that was not available.

4. For Resident# 22, facility staff failed to provide supervision to the resident who was providing her own care for two surgical drains, failed to assess the resident's ability to care for her own surgical drains, and failed to develop an initial plan of care for the surgical drains.

The findings include:

1 a. For Resident # 34, facility staff failed to perform a nursing assessment of a leg wound at the time of admission, and documented dressing changes as being performed that were not being done.

Resident# 34 in the survey sample, a 90 year-old female, was admitted to the facility on 6/12/16

F 281

5-371-200 (B) (1) (ii)

1. Resident # 34 was transferred to the ER and went home thereafter on 6/30/2016.
Resident #20 G-tube placement was confirmed on 6/28/16. Resident #20 nurse on 6/28/2016 was re-educated on checking for feeding tube placement prior to medication administration and tube feeding on the same day of the incident.
Resident #21 G-tube placement was confirmed on 6/28/16. Resident #21 nurse on 6/28/2016 was re-educated on checking for feeding tube placement prior to medication administration and tube feeding on the same day of the incident.
Resident# 21 nurse was re-educated on 6/28/2016 on signing for medication not given as given, correction made on MAR and MD notified on 6/28/16.Resident #22 discharged home on 7/11/2016.
2. Patients with active wounds will be audited to ascertain the presence of completed admission and weekly wound assessment and that signed TAR are true reflection of the treatment provided to the affected patient(s) by the nurses.
Demonstrative in services will be provided to all charge nurses routinely or as needed assigned to patients with feeding tubes on feeding tube placement checks.
Current patient with JP drains audited to ascertain that they are care planned, nurses are managing them, and where applicable patients educated on self-managing them. Any anomaly will be rectified accordingly.
3. Re-education nursing staff will be completed to include:

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with diagnoses that included cellulitis, lymphedema, generalized muscle weakness, cerebral infarction, edema, hypothyroidism, hypertension, vitamin deficiency, overactive bladder, and hyperlipidemia. According to a Medicare 14-Day Minimum Data Set (MOS) with an Assessment Reference Date (ARD) of 6/26/16, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15.

Under Section M (Skin Conditions) on the 14-Day MOS, the resident was assessed at Item M1040 (Other Ulcers, Wounds and Skin Problems) as having an infection of the foot. At Item M1200 (Skin and Ulcer Treatments), the resident was assessed as having a pressure reducing device having the application of nonsurgical dressings, and as having applications of ointments/medications.

A thorough review of Resident # 34's Electronic Health Record (EHR) and paper clinical record failed to reveal any documentation that her legs and leg wound were assessed by the facility staff at the time of admission, or at any time prior to 6/30/16, when the legs and wound were first observed by the facility staff and the survey team.

During an interview at 12:30 p.m. on 6/30/16, the resident's daughter said, "To my knowledge, no one here has ever seen the wound."

Resident# 34's EHR included two Weekly Skin Assessment forms, dated 6/22/16 and 6/29/16. The 6/22/16 Weekly Skin Assessment form included the following notation under Item A (Observations), "Cellulitis." Item 2 (Notes),

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a. Admission and weekly skin/wound assessment
b. Following doctor! s orders for wound treatment
c. Properly signing for medication/treatment not administered.
d. Management of JP drains and documented patient education
e. Feeding tube placement check

4. DON/Unit Managers/Designee will audit active JP drains for adequate nursing management, feeding tube for placement checks, current wounds for adm_ission and weekly a_ssessment; and 10% of TAR/MAR to ascertain that nursing signatures reflect the care provided weekly for one month, then monthly for two months, then quarterly for two more quarters. Any deviations will be forwarded to the QA committee to assure compliance.

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included the following entry, "Cellulitis present on both legs from feet to upper area of legs. Resident has order for lymphrdema [sic] wraps." There was no further description of the resident's legs or of her leg wound.

The 6/29/16 Weekly Skin Assessment form included the following notation under Item A (Observations), "Cellulitis." Item 2 (Notes), included the following entry, "Weekly skin assessment completed. Cellulitis present on both legs from feet to upper area of legs. Patient has order for lymphrdema [sic] wraps that patient prefers to get it wrapped at [name of hospital]." There was no further description of the resident's legs or of her leg wound.

1b. Resident # 34's Electronic Medication Administration Record (E-MAR) included the following order, dated 6/13/16, "Treatment - Lymphedema wraps every day shift lymphedema wraps to bilateral feet every day." The treatment order was signed off as having been performed daily from 6/13/16 through 6/30/16.

The E-MAR also included the following treatment order, dated 6/16/16 for the treatment of her leg wound, "Clean wound with N/S (Normal Saline), skin prep to peri-wound, primary dressing apply prisma AG, secondary dressing, piece of plain foam, (make sure to peel of [sic] plastic layer from back), then ABO pad if draining every day shift Mon [Monday], Wed [Wednesday], Fri [Friday] for wound care." Wound care was signed off on the E-MAR as having been performed on 6/17/16, 6/20/16, 6/22/16, 6/24/16, 6/27/16 and 6/29/16.

During an interview at 12:30 p.m. on 6/30/16, the

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resident's daughter said she and her sister have done the wraps and wound care several times. "I told the nurses I would prefer if they don't touch the legs," the resident's daughter said.

Review of the facility's policy "General Wound Care/Dressing Changes" noted the following:

"POLICY: A licensed nurse will provide wound care/dressing change(s) as ordered by physician."

At 1:10 p.m. on 6/30/16, two of the staff members who signed off the E-MAR as having performed the lymphedema wraps and wound care were interviewed. RN# 7 (Registered Nurse) said, "We don't do dressing changes, her daughter does them. We are not allowed to. We used to do it but we did not do it correctly."

RN # 8 stated, "We are just documenting that the dressings are intact, not that we are doing it. Sometimes I document in the Nurses Notes that the dressing is intact." RN# 8 went on to say that the Nurse Practitioner was made aware that staff is not doing dressing changes, but she (the Nurse Practitioner) did not write and new orders.

The Potter-Perry Fundamentals of Nursing notes the following regarding documentation, "Accurate documentation is one of the best defenses for legal claims associated with nursing care. To limit nursing liability, nursing documentation must clearly indicate that individualized, goal-directed nursing care was provided to a client based on the nursing assessment." Potter-Perry further notes that, "Records need to reflect accountability during the time frame of entry. This is accomplished when nurses chart only their own

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observations and actions. The signature holds that nurse accountable for information recorded." (Ref. Potter-Perry Fundamentals of Nursing, 7th Edition, pages 387 - 389.)

2. For Resident # 20, staff failed to check feeding tube placement prior to the administration of medications and tube feeding.

Resident# 20 in the survey sample, a 72 year-old male, was admitted to the facility on 10/2/15 with diagnoses that included ventricular fibrillation, mononeuropathy, generalized muscle weakness, hyperlipidemia, hypertension, anemia, enlarged prostate, arteriosclerotic heart disease, deep vein thrombosis, shortness of breath, depressive disorder, gastroesophageal reflux disease, and gastrostomy tube placement. According to the most recent Quarterly Minimum Data Set (MOS), with an Assessment Reference Date of 5/10/16, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 14 out of 15.

Resident# 20, whose dietary status was NPO (nothing by mouth), had a diet order for "Enteral feeding every 4 hours for Nutrition, Jevity 1.5 at 237 ml [milliliters] bolus via G-tube [Gastrostomy] Q [every] 4 hours."

During the medication pass and pour observation at 9:05 a.m. on 6/28/16, LPN# 5 (Licensed Practical Nurse), the Fourth Floor Charge Nurse, was observed administering tube feeding and mediations to Resident # 20, who received all nutrition and medications through a gastrostomy tube. After administering five medications and one 237 ml can of Jevity 1.2, LPN # 5 looked at the surveyor and said, "I don't have my

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stethoscope, I did not check for bowel sounds."

Review of the facility policy titled "Care of the Patient with a Feeding Tube," furnished by the Director of Nursing (DON), revealed the following under the section "Procedure: General Principles related to Enteral Feeding:"

"5. Verify placement of feeding tube PRIOR [sic] to infusion of formula...."

The policy also notes the following under the section "Procedure: Medication Administration"

"4. Verify tube placement and residual amounts."

Interviewed after the completion of the medication pass and pour for Resident # 20, LPN # 5 admitted that he did not check the placement of the feeding tube and did not check for feeding tube residual.

3a. For Resident# 21, facility staff failed to correctly check the placement of a feeding tube prior to the administration of medications and tube feeding, and signed as having administered a medication that was not available.

Resident# 21 in the survey sample, an 88 year-old male, was admitted to the facility on 2/10/16 with diagnoses that included bilateral pneumonia, mononeuropathy, hypertension, contractures, dementia, dysphagia, depressive disorder, seizures, and PEG (Percutaneous Endoscopic Gastrostomy) tube placement. According to the most recent Quarterly MOS, with an ARD of 6/21/16, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary

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Score of 00 out of 15.

Resident# 21 had the following order for feeding, dated 6/27/16, "Enteral feed order every shift for nutrition Jevity 1.2@ 60ml/hr [60 milliliters per hour] x [times] 24 hours via GT [g-tube]."

During the medication pass and pour observation at 9:50 a.m. on 6/28/16, LPN# 5 stopped the tube feeding pump and disconnected the feeding supply tube from the feeding tube. Prior to the administration of medications through the feeding tube, LPN # 5 took a large bore feeding syringe, and while listening to the resident's abdomen with a stethoscope, injected air into the feeding tube. LPN# 5 then administered five medications through the feeding tube, after which he reconnected the feeding tube to the feeding tube pump.

The facility policy titled "Care of the Patient with a Feeding Tube," notes the following under the section "Procedure: Verification of Feeding Tube Placement:"

"1. Correct placement of a feeding tube will be checked by aspiration of gastric contents and auscultation immediately prior to the administration of any water flush, prescribed medication and nutritional feedings via the enteral route. (Ausculatation of air as the sole determinant of feeding tube placement is no longer considered the best method of verifying tube placement.)"

During an end of day meeting with the facility's administrative staff and the survey team at 3:30 p.m. on 6/28/16, the DON confirmed that auscultation (injection of air) was not the

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preferred method of verifying feeding tube placement.

3b. Resident# 21 had an order, dated 6/28/16, for the following medication, "Sertraline HCL Tablet 50 mg [milligrams]. Give 50 mg via G-tube , one time a day." During preparation of medications for administration, LPN # 5 said, "Zoloft [Sertraline] is not available. I will call the pharmacy."

During reconciliation of medications administered ; with medications ordered, it was noted that Sertraline was documented on the E-MAR as having been administered. At approximately 10:30 a.m. on 6/28/16, LPN# 5 was interviewed regarding the Sertraline entry on the E-MAR. LPN # 5 admitted he had entered the Sertraline as having been given, even though it was not available. "I was nervous and I clicked [entered] it by mistake."

The Potter-Perry Fundamentals of Nursing notes the following regarding documentation during the administration of medications, "After administering a medication, indicate which medications were given on the client's MAR...Nurses never document that they have given a medication until they have actually given it." (Ref. Potter-Perry Fundamentals of Nursing, 7th Edition, page 709.)

4. Resident #22 was admitted to the facility on

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06/27/2016 with two JP (Jackson Pratt) drains from abdominal surgery. Resident #22 was measuring the drainage from her own drain without staff supervision or assessment. In addition, the JP drains were not addressed on the initial (interim) plan of care.

Findings were:

Resident #22 was admitted to the facility on 06/27/2016 status post laparotomy, cytorecleidian with HIPEC (hyperthermic intraperitoneal chemotherapy), omentectomy, peritinectomy, appendectomy, LAR (lower anterior resection), TAH with BSO (total abdominal hysterectomy with bilateral salpingo-oopherectomy) and cholecystectomy. Her admitting diagnoses included but were not limited to: Pain, Major depressive disorder, venous thrombosis, anxiety, Peritoneal Metastasis, malignant ascitis, mucinous adenocarcinoma of appendix and PTSD (post traumatic stress disorder).

Due to Resident #22's recent admission there was no MOS (minimum data set) assessment completed.

Initial tour of the facility was conducted on 06/28/2016 beginning at approximately 7:30 a.m. During tour Resident #22 was observed lying on her bed, completely dressed. A urinal with yellow fluid was observed on her bedside table. This surveyor spoke to the resident. She stated that she had just been admitted the day before (06/27/2016) at around 3:00 p.m. She stated, "I haven't seen much of the nurse's yet...they are busy as hell up here...I got here yesterday as the second shift was coming in..." During the conversation Resident #22 stated, "I had

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extensive surgery...! have a hot pack implanted to give me chemo...I did have four JP drains but now I am down to 2." She pointed to the urinal and stated, "I take care of them myself...they gave me a urinal to measure the drainage in...they haven't been in here yet to get it." Resident #22 was asked who taught her to empty the drains. She stated, "They showed me at the hospital." She was asked if anyone at the facility had watched her do it. She stated, "No, I'm telling . you they've hardly been in here...I need a shower · and I need to tell them what all I am allergic to."

On 06/29/2016 at approximately 1:00 p.m., this surveyor returned to Resident #22's room. She stated, that she had gotten a shower the day before and had spoken to the nurse's about her allergies. Resident #22 was asked if she was emptying her JP drains. She stated, "Yes, of course." Resident #22 was asked if the facility staff had observed her doing so. She stated, "No, they just come in here and get the fluid to see how much it was after I empty it."

The clinical record was reviewed. Contained on the physician order sheet were the following orders concerning the JP drains: "Monitor Output , and document amount in JP drains every shift for drainage amount from JP drains. Cleanse JP drain site with NS (normal saline), pat dry and apply dry dressing daily, every shift for wound care." There were no orders regarding Resident #22's self care of the JP drains. The initial care plan was reviewed. There was no mention on the care plan of Resident #22 having JP drains.

The unit manager, RN (registered nurse) #1 was interviewed on 06/29/2016 at approximately 2:00 p.m., regarding Resident #22's JP drains. He

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stated, "No, we are emptying them." The conversation with Resident #22 was discussed with him. He stated, "She must be doing that without our knowledge." He then went to the nurse's station and spoke with the staff sitting there. RN #2 stated, "Yes, she does it." The unit manager asked RN #2 if she had watched Resident #22 empty her drains. She stated, "No, I have not worked with her, but I know the other nurse's said she does it herself...we record the amount." The unit manager asked if Resident #22 should be assessed for self care of the JP drain and should it be on the initial care plan. He stated, "Yes, if she is doing it we should assess her knowledge and put it on the care plan."

According to Potter and Perry, Fundamentals of Nursing 6th Edition, on page 1507 regarding JP drains, "The physician inserts a drain into or near a surgical wound if a large amount of drainage is expected...the nurse assesses the number of drains, drain placement, character of drainage and condition of collecting apparatus...If there is a collecting device, the nurse measures the drainage volume. Because a drainage system must be patent, the nurse looks for drainage flow through the tubing, as well as around the tubing...Evacuator units such as a ...Jackson-Pratt exert a constant low pressure as long as the suction device (bladder or bag) is fully compressed...when the evacuator device is unable to maintain a vacuum on its own, the nurse notifies the surgeon who can them order a secondary vacuum system...if fluid is allowed to accumulate within the tissues, wound healing will not progress at an optimal rate and the risk of infection is increased." (1)

Pages 472 - 473 of the same reference discusses

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evaluation and documentation of patient teaching: "Client education is not complete until the nurse evaluates outcomes of the teaching-learning process...because client teaching often occurs informally between nurse and client it is difficult to document it consistently. A nurse is legally responsible for providing accurate, timely client information that promotes continuity of care; therefore it is essential to document the outcomes of teaching...document the following regarding client education: Assessment data and reassessment of learning needs...Client response and outcomes of care, document evidence of learning (e.g. a return demonstration...)" (1)

In regards to care planning the same source cites on page 327, "A nursing care plan is a guide for clinical care. It also serves as a document that communicates a client's nursing care to all team members...a written care plan is designed to direct clinical care and to decrease the risk of incomplete, incorrect or inaccurate care." (1)

The above information was discussed with the DON (director of nursing), the administrator and the regional nurse consultant during a meeting on 06/29/2016 at approximately 4:1O p.m.

No further information was obtained prior to the exit conference on 06/30/2016.

(1) Potter, Perry. Fundamentals of Nursing Practice, 6th Edition. Mousy. St. Louis, Missouri. 2005.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

F 309.

8/1/16

Each resident must receive and the facility must

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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:

Based on complaint investigation, observations, clinical record review, staff interview, family interview, and facility document review, the facility staff failed for one of 34 residents in the survey sample (Resident# 34) to assess, monitor, and provide physician ordered treatment and services to address the resident's lymphedema, cellulitis, and a leg wound on multiple occasions. The failure of the facility to provide assess, monitor, and provide the necessary care and services resulted in the identification of Immediate Jeopardy and Sub-standard Quality of Care. The facility Administration was notified of the finding of Immediate Jeopardy at 3:15 p.m. on 6/30/16. Following the presentation and acceptance of a Plan of Removal, the finding of Immediate Jeopardy was lifted at 5:00 p.m. on 6/30/16. Subsequently, the Scope and Severity of the finding was reduced to Level 2, pattern.

In addition, the facility staff failed for one of 34 residents in the survey sample (Resident# 4) to follow physician's orders for the provision of care.

The findings include:

1. The facility staff failed to assess and provide physician ordered treatment and services to address the resident's lymphedema, cellulitis, and

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F309 Cross Reference to 12 VAC 5-371-220 (8) and (8)

1. Resident # 34 was transferred to the ER and went home thereafter on 6/30/2016. Daily weight order for Resident, #4 was updated to include supplemental documentation of weights taken by the nurses on 6/28/2016 and changed to weekly weight check order on 7/19/2016

2. All refusals of staff performance of wound care or lymphedema wrapping will be reviewed for proper documented **patient education on the risk of refusing** treatment, MD notification, and transfer to the hospital as appropriate. All current patients on daily weights will be reviewed to ascertain that they are completed, recorded, and followed upon as ordered by the physician. Any anomaly will be rectified immediately.

3. Re-education of facility nursing staff on the following:

a. MFA policy on Refusal of Medication/Treatment Care

b. Following doctorl s order for lymphedema and wound treatment

c. Weekly assessment, monitoring, and treatment of wound/cellulitis/lymphedema wrap

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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)	(XS) COMPLETION DATE

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a leg wound.

Resident# 34 in the survey sample, a 90 year-old female, was admitted to the facility on 6/12/16 with diagnoses that included cellulitis*, lymphedema**, generalized muscle weakness, cerebral infarction (a type of stroke), edema***, hypothyroidism, hypertension, vitamin deficiency, overactive bladder, and hyperlipidemia****. According to a Medicare 14-Day Minimum Data Set (MOS) with an Assessment Reference Date (ARD) of 6/26/16, the resident was assessed **under Section AC (Cognitive Patterns) as being** moderately cognitively impaired, with a Summary Score of 9 out of 15.

*Cellulitis is an infection of the skin and deep underlying tissues.

**Lymphedema is the name of a type of swelling. It happens when lymph builds up in your body's soft tissues. Lymph is a fluid that contains white blood cells that defend against germs. It can build up when the lymph system is damaged or blocked. It usually happens in the arms or legs.

***Edema means swelling caused by fluid in your body's tissues

****Hyperlipidemia is an abnormally high concentration of fats or lipids in the blood

Under Section M (Skin Conditions) on the 14-Day MOS, the resident was assessed at Item 1040 (Other Ulcers, Wounds and Skin Problems) as having an infection of the foot. At Item 1200 (Skin and Ulcer Treatments), the resident was assessed as having a pressure reducing device for bed, as having the application of non-surgical

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d. Proper treatment documentation
e. Checking and Monitoring of daily weight order

4. The DON/ADON/Unit Managers will audit all current patients with lymphedema wraps and wounds on an ongoing basis weekly for one month, then monthly for two months, then quarterly for two more quarters to ascertain treatment order completion and adequate follow-up on the refusal of treatment as applicable.

DON/Unit Managers/Designee will also audit weekly x4 weeks, monthly x2, and quarterly x1 quarter all daily weight orders to ensure that they are being completed as ordered. Any deviations will be forwarded to the QA committee for resolution.

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dressings, and as having applications of ointments/medications.

A thorough review of Resident# 34's Electronic Health Record (EHR) and paper clinical record failed to reveal any documentation that her legs and leg wound were assessed by the facility staff at the time of admission, or at any time prior to 6/30/16, when the legs and wound were first observed by the facility staff and the survey team.

Resident# 34's EHR included two Weekly Skin Assessment forms, dated 6/22/16 and 6/29/16. The 6/22/16 Weekly Skin Assessment form included the following notation under Item A (Observations), "Cellulitis." Item 2 (Notes), included the following entry, "Cellulitis present on both legs from feet to upper area of legs. Resident has order for lymphrdema [sic] wraps." There was no further description of the resident's legs or of her leg wound.

The 6/29/16 Weekly Skin Assessment form included the following notation under Item A (Observations), "Cellulitis." Item 2 (Notes), included the following entry, "Weekly skin assessment completed. Cellulitis present on both legs from feet to upper area of legs. Patient has order for lymphrdema [sic] wraps that patient prefers to get it wrapped at [name of hospital]." There was no further description of the resident's legs or of her leg wound.

At approximately 12:30 p.m. on 6/30/16, the resident's daughter came to the facility and met with the survey team. The resident's daughter said she has taken care of her mother's legs at home for eight years. "I have been trained to perform leg wraps for lymphedema. There is no

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one here qualified to do them. I told the nurses I would prefer if they don't touch the legs," the resident's daughter said. The daughter went on to say that she will not allow the facility's nursing staff to change the wraps and dressing on her mother's legs. "I change them every three days," she said. She admitted she has not told the facility how many times she has changed the wraps.

According to the daughter, the Administrator offered to have one of two Physical Therapists who have been trained in lymphedema care do the wraps and dressing changes. "I refused," she said. "The therapist wanted to leave the wound open to the air so it would heal, but that's not what the wound clinic wanted, that's not what I want."

Continuing, the daughter said she takes her mother to (name of hospital) wound clinic for dressing and wrap changes, the last time being on 6/16/16. According to the daughter, she does i not have an order to go to the wound clinic, but makes an appointment when she wants to take her mother there.

"To my knowledge," the daughter said, "no one here has ever seen the wound."

The survey team asked the resident's daughter if she would consent to the removal of the wraps , and dressing so the resident's legs and the wound could be assessed. After some discussion, the daughter agreed to remove the dressings from Resident# 34's lower extremities to allow the survey team visualization of the resident's legs as well as the wound.

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	F 309 : Continued From page 58 On 06/30/2016 at approximately 1:10 p.m., two members of the survey team accompanied the daughter to Resident# 34's room. This surveyor went to the nurse's station and requested for a staff member to be present during the wound care. LPN (Licensed Practical Nurse)# 7 stated, "We don't do her dressing changes, her daughter does them." This surveyor replied, "[Name of daughter] is here and agreed to do the dressing change for the survey team. We need a staff member in the room as well." She stated, "I will get her nurse, [Name of LPN # 8]. The two surveyors went into Resident# 34's room. The daughter was in the room. The resident was observed in her bed, with the head of the bed at approximately 90 degrees. She was covered in blankets and stating that she was cold. The daughter requested a towel which she placed under the resident's leg and she then began unwrapping the right leg. A white geri-leg sleeve was observed with brown, dried, odiferous drainage. The sleeve was pushed up revealing a woolen sock which was taped to the layers of material under it with masking tape. The tape and the sock were removed. Another white geri sleeve was under the sock and taped in the same manner as the sock. Both were removed. The next layer was a foam dressing. The daughter stated that the foam dressing was the lymphedema wrap. As each layer was removed the odor from the drainage of the leg increased. When the last layer was removed, a nonstick rectangular gauze was observed over the outer aspect of the right ankle. The gauze had a brown area the approximate size of a fifty cent piece. The skin of the right leg that had been unwrapped was observed. The	F 309		

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skin was dry, dark and cracked. The toes of the right foot had been amputated in the past. Folded gauze was observed in the area of amputation. The daughter stated that the gauze was covering a corn. The lower leg from approximately one inch above the still covered wound to the ankle was red. The daughter was asked if the area was hard. She felt it and stated, "No, it's soft."

The daughter stated, "All my supplies are in my car." She requested the LPN's in the room to get her some saline. LPN # 8 brought in bottles of sterile water which the daughter used to clean the leg. As she wiped chunks of dried dead skin came off of the leg. She stated, "That's the way they do it at the hospital ...they just pull it off." She also stated, "...her leg is reeping [sic]...she has the staph infection again...see it's not green [referring to the drainage]." The daughter continued to wipe the leg and put the dead skin on the towel under the resident's leg. She then poured sterile water over the nonstick dressing to remove it.

Once the nonstick dressing was removed yellow drainage was observed on the outer aspects of where the dressing had been and on the dressing itself. The wound was approximately 3 inches long and approximately 1 inch in the widest part. The borders were irregular. The wound bed was pink with yellow exudate observed. The odor from the wound and the leg was strong and foul. LPN # 7 and LPN # 8 were asked if there were any measurements available for the wound. They both shook their heads side to side, indicating, no. LPN # 7 and LPN # 8 were asked if they had seen the wound before they both stated, "No." The daughter was asked when she

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had last done the dressing change. She stated, "Saturday [June 25, 2016]." The daughter also stated that she did not always change the gauze over the wound every time she did the lymphedema wraps.

At approximately 11:30 a.m. on 6/30/16, one of the two Physical Therapists (PT) trained in lymphedema treatment was interviewed. The PT acknowledged she had offered to unwrap the legs, and that she had recommended the wound be left open to the air to facilitate healing, but that **the daughter had refused. The PT also stated** that rewrapping the leg with the wound would be contraindicated by physical therapy standards due to the possibility of spreading the infection.

Resident# 34's Electronic Medication Administration Record (E-MAR) included the following order, dated 6/13/16, "Treatment - Lymphedema wraps every day shift lymphedema wraps to bilateral feet every day." The treatment order was signed off as having been performed daily from 6/13/16 through 6/30/16.

The E-MAR also included the following treatment order, dated 6/16/16 for the treatment of her leg wound, "Clean wound with N/S [Normal Saline], skin prep to peri-wound, primary dressing apply prisma AG, secondary dressing, piece of plain foam, (make sure to peel of [sic] plastic layer from back), then ABO pad if draining every day shift Mon '[Monday], Wed [Wednesday], Fri [Friday] for wound care." Wound care was signed off on the E-MAR as having been performed on 6/17/16, 6/20/16, 6/22/16, 6/24/16, 6/27/16 and 6/29/16.

Review of the facility's policy "General Wound

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Care/Dressing Changes" noted the following:

"POLICY: A licensed nurse will provide wound care/dressing change(s) as ordered by physician."

At 1:10 p.m. on 6/30/16, two of the *staff* members who signed *off* the E-MAR as having performed the lymphedema wraps and wound care were interviewed. RN# 7 (Registered Nurse) said, "We don't do dressing changes, her daughter does them. We are not allowed to. We used to do it but we did.not do it correctly."

, RN # 8 stated, "We are just documenting that the dressings are intact, not that we are doing it. Sometimes I document in the Nurses Notes that the dressing is intact." RN# 8 went on to say that! the Nurse Practitioner was made aware that staff is not doing dressing changes, but she (the Nurse Practitioner) did not write and new orders.

At approximately 3:00 p.m. on 6/30/16, a telephone interview was conducted with the resident's attending physician, who also serves as the Co-Medical Director. The physician . admitted he has never seen the resident's leg wound. He also said he did not know the . resident's daughter had taken her to the wound clinic.

The physician went on to say he was aware the . resident and her family were non-compliant with the treatment orders for her lymphedema and leg wound. "We talked to the family multiple times," the physician said. "If the family is going against doctor's wishes for treatment, we just accept it." The physician inferred there was not much he could do to address the family's/resident's

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non-compliance. Asked if he had any notes of his conversations with the resident and her family, the physician said, "I don't recall."

Review of the facility policy "Refusal of Medication/Treatment Care" noted the following:

"POLICY: A licensed nurse is to document and notify the physician and responsible party when a patient refuses medication(s) and/or treatment.

Following the notification of Immediate Jeopardy, at 3:15 p.m. on 6/30/16, the facility submitted the following Plan of Removal:

"The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.

1) Patient # 34 will be sent to [name of hospital] for evaluation per MD order, APS referral will be made to ensure patient welfare.
2) All refusals of staff performance of wound care or lymphedema wrapping will be reviewed for proper documentation, MD notification, APS referral as appropriate.
3) Nurses will be in serviced on:
a. Refusal of care protocols including MD notification.

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	F 309 : Continued From page 63 b. Proper treatment documentation. c. Skin/Wound Assessment. 4) Administrator and DON will review audit findings. 5) Date of compliance June 30, 2016." The Plan of Removal was reviewed and accepted by the survey team at 5:00 p.m. on 6/30/16. COMPLAINT DEFICIENCY 2. Resident #4 was not weighed daily per physician orders. Findings were: Resident #4 was most recently readmitted to the facility on 05/23/2016. Her diagnoses included, but were not limited to: Fluid overload, heart failure, acute kidney failure, hypertension, atrial fibrillation, type II diabetes mellitus, COPD (chronic obstructive pulmonary disease), respiratory failure, obstructive sleep apnea, and obesity. The most recent MOS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 04/12/2016. Resident #4 was assessed as having a cognitive summary score of "1O", indicating moderate impairment with her cognitive status. The clinical record was reviewed on 06/28/216. Observed on the POS (physician order sheet) was an order dated 05/23/2016 for "Daily weight in the morning related to HEART FAILURE, UNSPECIFIED 9150.9); FLUID OVERLOAD,	F 309,		

DEPARTMENT OF HEALTH AND HU SERVICES
CENTERS FOR MEDICARE & MEDlcJil> SERVICES

FORM APPROVED
0MB NO 0938-0391

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UNSPECIFIED (E 87. 70) Notify MD [medical doctor] if weight gain is 2-3 lbs [pounds] within 2-3 days, change in SOB [shortness of breath], lower leg swelling, chest pain or pressure.

The weight section of the clinical record was reviewed. Daily weights were recorded from 05/24/2016 through 06/08/2016. From 06/09/2016 through 06/28/2016, a total of 20 days 20 opportunities, five weights were recorded.

On 06/28/2016 the unit manager, LPN (licensed practical nurse) #1 was interviewed regarding weights for Resident #4. She asked RN (registered nurse) #4 if he had was weighing Resident #4. He stated, "Yes." LPN #1 asked RN #4 to go see what weights he could find. He returned with a piece of paper and stated "These are her weights from the weekend." The handwritten paper contained two weights dated from the previous weekend .He was asked where the paper came from. He stated, "I just wrote them." There was no name on the paper or any other weights

LPN #1 and RN #4 were interviewed regarding the weights. **RN** #4 stated, "I weigh her everyday when I am here. I don't write the weights down if they are in the parameters." RN #4 was asked how the next person would know what the weights were and if the doctor needed to be notified if he didn't write the weights down when he got them. He did not answer. LPN #1 stated, "The weights should be in the computer not on paper."

The administrator, the DON (director of nursing) and the corporate nurse consultant were notified of the above information during and end of the

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F 309	Continued From page 65 day meeting on 06/28/2016. The administrator stated, "We are currently going through pieces of paper to find the weights." Eight additional days of weights were presented on handwritten pieces of paper. Weights were not obtained every day as ordered by the physician. No further information was obtained prior to the exit conference on 06/30/2016.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on, observation, resident interview, staff interview, and clinical record review, the facility staff failed to properly secure an indwelling catheter for 1 of 34 residents in the survey sample, Resident #15. Resident #15 catheter tubing was not anchored to prevent pulling on the tube.	F 315	F315 Cross Reference to 12 VAC 5-371-220 (C) (3) 1. Resident #15 Foley catheter tube anchor replaced on 6/28/16 2. An audit of all residents with Foley catheters will be conducted to determine if they are secured with an anchor. Those not secured with an anchor will be replaced with one accordingly	8/1/16

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Findings include:

Resident #15 was admitted to the facility on 4/7/16 with a readmission on 6/24/16 with diagnoses including, but not limited to: Gout, hypertension, osteoarthritis, urine retention, anxiety, personality disorder, obesity, and soft pallet cancer.

The most recent MOS (minimum data set) was a 14 day assessment with an ARD (assessment reference date) of 4/21/16. Resident #15 was assessed as being cognitively intact with a total cognitive score of 13 out of 15.

Resident #15's electronic record was reviewed on 6/28/16 and evidenced, via care plan, that Resident #15 had an indwelling catheter due to urinary retention. Interventions for the catheter , included; "Monitor/document for pain/discomfort due to catheter."

On 6/28/16 at 2:00 p.m. Resident #15 was observed lying in bed. This surveyor knocked the door and entered the room. The Foley bag was hanging on the side of the bed and was observed with some blood tinged urine in the catheter bag. Resident #15 did not communicate well due to a history of soft pallet cancer, but could verbalize "yes, no" and shake and nod his head.

Resident #15 was asked if the catheter tubing was anchored to his leg, Resident #15 replied "no." Resident #15 was asked if the tubing was causing any discomfort and was able to communicate that there was a little discomfort.

At this time 2 certified nursing assistance (CNA's) came into the room along with a registered nurse

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3. Re-education of the nursing staff will be completed on the following:
a. Anchoring Foley catheter
b. Replacing Foley catheter tubing anchors as needed.
4. The DON/Unit Manager/Designee will audit all patients with Foley catheters **weekly for one month, then monthly for** two months, then quarterly for two more quarters to ensure that they are anchor persistently. Any deviations will be forwarded to the QA committee for resolution.

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(RN). This surveyor asked Resident #15 permission to look at his genital area and Resident #15 gave permission. This surveyor then asked CNA #1 to remove the covers and lower Resident #15's brief. There were no concerns with the genital area, but the catheter tubing was underneath the right buttock and not anchored.

This surveyor asked RN #7 and CNA #1 about anchoring the catheter. RN #7 verbalized that maybe the tubing came loose during a transfer earlier that day. This surveyor then asked Resident #15 if it had came loose, Resident #15 shook his head no. Resident #15 was asked if the staff had anchored the tubing to his leg this morning Resident #15 verbalized, no.

On 6/28/16 at 4:00 p.m. the above finding was brought to the attention of the administrator and director of nursing (DON). The DON was asked what the expectation would be for a Foley catheter in regards to securing the tubing to prevent dislodging or causing discomfort due to pulling of the tubing. The DON verbalized that catheter tubing should be anchored.

No further information was presented prior to exit conference on 6/30/16.

The Lippincott Manual of Nursing Practice 10th Edition on page 777 defines suprapubic catheterization as placement of a catheter that, " ...establishes drainage from the bladder by introducing a catheter percutaneously or by an incision through the anterior abdominal wall into the bladder. It may be done for acute urinary retention when urethral catheterization is not possible; for urethral trauma, stricture, or fistula to

F 3151

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F 315

i divert flow of urine from the urethra ... " (1)

The Lippincott Manual of Nursing Practice 10th Edition on page 781 documents in steps for management of a patient with an indwelling urinary catheter, " Secure the indwelling catheter to patient's thigh using tape, strap, adhesive anchor, or other securement device ...Allow some slack of the tubing to accommodate the patient's movements ...Keep the tubing over the patient ' s leg ...In the male patient, the indwelling catheter is taped to the thigh to straighten the angulation **of the penoscrotal junction, thus reducing** pressure on the urethra exerted by the catheter. " This reference states properly securing the catheter tubing prevents movement and traction on the urethra and prevents kinking or formation of loops in the tubing that could lead to stagnant urine. (1)

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer . Health/Lippincott Williams & Wilkins, 2014.

F 318 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION
SS=D

F 318 — 8/1/16

Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff

F318 Cross Reference 12 VAC

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interview and clinical record review, the facility staff failed to ensure proper, timely assessment and documentation for the use of devices for one of 34 residents, Resident #7.

Resident #7 was admitted to the facility on 06/09/2015 with bilateral AFO's (ankle foot orthosis). The clinical record did not contain any documentation regarding the use of the devices or an assessment/diagnosis to determine the need for the devices.

Findings were:

Resident #7 was admitted to the facility on 06/15/2015. His diagnoses included but were not limited to: Type II diabetes mellitus, hypertension, Alzheimer's, dementia and GERD (gastro esophageal reflux disease).

The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 05/31/2016. Resident #7 was assessed as having a cognitive summary score of "09", indicating moderate impairment with his cognitive status.

On 06/28/2016 at approximately 2:30 p.m., Resident #7 was observed lying in bed with his eyes closed. Beside his bed were a pair of shoes with leg braces extending from each shoe.

The clinical record was reviewed. There were no orders on the POS (physician order sheet) for June for any type of lower extremity device. The care plan was also reviewed. There were no entries on the care plan related to a need for lower extremity devices or their usage.

F 318

5-371-250 (A)

1. Resident #7 assessed by PT and determine appropriate to use AFO on 6/29/2016. Physician order obtained on 6/29/2016 authorizing use of AFO. Device assessment completed to include the AFO on 6/29/2016 and care plan updated on 7/19/2016.
2. An audit of all residents with active AFO will be conducted by 6/29/16 to determine that appropriate assessment and order are in place. Those not in compliance will be updated accordingly.
3. Re-education of nursing staff will be completed to include:
   a. Appropriate assessment and order for residents with AFC/splints.
4. The DON/Unit Manager or designee will audit all patients with AFC/splints on an ongoing basis weekly for one month, then monthly for two months, then quarterly for two more quarters. Any deviations will be forwarded to the QA committee for resolution.

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F 318	Continued From page 70 On 06/29/2016 at approximately 10:05 a.m., Resident #7 was observed sitting up in bed. He was jovial but pleasantly confused. He stated that he had been at the facility "about a week...I'll be going back soon." A pair of shoes with splints protruding from each were again observed at the bedside. Resident #7 was asked about the splints protruding from his shoes. He reached down beside the bed and picked up one of the splints. This surveyor could then observe that the splints were AFO splints. The splint was made of hard white plastic material and was in the shape of the resident's lower leg and foot. He stated "This thing? I bought my s oes like this." Resident #7 was asked what the splint was for. He stated, "I don't know, they came with the shoes. Do you like them?" This surveyor spoke with the ADON (assistant director of nursing) at approximately 10:15 a.m. She was asked if she knew why Resident #7 had splints/ AFO's in his shoes. She stated that she did not know that he had splints. She then asked RN (registered nurse) #4 if he knew anything about the splints. He shook his head side to side, got up and left the nurse's station. The ADON was asked to look at the care plan and the POS with this surveyor. She was asked if she saw any information regarding the splints/AFO's. She stated, "No." The ADON was asked if she thought the splints/AFO's should be on the POS and/or the care plan. She stated, "Yes, it should be on the care plan." The administrator, the DON (director of nursing) and the corporate nurse consultant were notified of the above information during a meeting on 06/29/2016. The administrator stated that therapy had evaluated Resident #7 that day to	F 318:		

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determine the need for the splints. He state·d the splints had come in with the resident at the time of admission. He was not assessed at that time but had been evaluated by PT (Physical Therapy) that day (06/29/2016) and it was determined that the splints/AFO's were appropriate for the resident's usage. The administrator and the **corporate nurse consultant stated that the splints** were considered to be "Devices and a physician's order is not needed for devices...but they should be on the plan of care."

The physical therapy evaluation was requested and received. The following information was gleaned from the evaluation: "Pt (patient) referred to PT for functional mobility assessment to determine the need for B (bilateral) AFO's...GaitAnalysis: Gait pattern: PT demonstrated B foot drop and required excessive B hip/knee flex for foot clearance to prevent tripping on toes during trail 1 w/o (without) using B AFO's. On trial 2 pt no longer needed excessive hip/knee flex for foot clearance d/t (due to) wearing B AFOs however it was noted that the pt also had narrow BOS (base of support) and increase trunk flex...Skilled Justification Reason for Skilled Services: no further therapy warrented [sic] at this time. Pt benefits from use of B AFOs for functional mobility..."

No further information was obtained prior to the exit conference on 06/30/2016.

F 322 I 483.25(g)(2) NG TREATMENT/SERVICES - F 322 8/1/16
SS=D RESTORE EATING SKILLS

Based on the comprehensive assessment of a resident, the facility must ensure that --

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F 322	Continued From page 72 (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		
	This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, review of facility policy, and staff interview, the facility staff failed for two of 34 residents in the survey sample (Residents# 20 and 21) to provide: care and services for a feec!ing tube during medication and tube feeding administration. 1. For Resident# 20, staff failed to check feeding tube placement prior to the administration of medications and tube feeding. 2. For Resident# 21, facility staff failed to correctly check the placement of a feeding tube prior to the administration of medications and tube feeding. The findings include:		F322 Cross Reference to 12 VAC 5-371-220 (C) (5) 1. Resident #20Ds nurse on 6/28/2016 was re-educated on checking for feeding tube placement prior to medication administration and feeding on the same day of the incident. Resident #21cs nurse! on 6/28/2016 was re-educated on checking for feeding tube placement prior to medication administration and feeding on the same day of the incident. 2. Demonstrative in-services will be provided to nurses routinely or as needed assigned to patients with feeding tubes on appropriate techniques to check feeding **tube placement.** 3. Re-education of the nursing staff will	

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1. For Resident# 20, staff failed to check feeding tube placement prior to the administration of medications and tube feeding.

Resident# 20 in the survey sample, a 72 year-old male, was admitted to the facility on 10/2/15 with diagnoses that included ventricular fibrillation, mononeuropathy, generalized muscle weakness, hyperlipidemia, hypertension, anemia, enlarged prostate, arteriosclerotic heart disease, deep vein thrombosis, shortness of breath, depressive disorder, gastroesophageal reflux disease, and gastrostomy tube placement. According to the most recent Quarterly Minimum Data Set (MOS), with an Assessment Reference Date of 5/10/16, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 14 out of 15.

Resident # 20, whose dietary status was NPO (nothing by mouth), had a diet order for "Enteral feeding every 4 hours for Nutrition, Jevity 1.5 at 237 ml (milliliters) bolus via G-tube (Gastrostomy) Q (every) 4 hours."

During the medication pass and pour observation at 9:05 a.m. on 6/28/16, LPN# 5 (Licensed Practical Nurse), the Fourth Floor Charge Nurse, was observed administering tube feeding and mediations to Resident # 20, who received all nutrition and medications through a gastrostomy tube. After administering five medications and one 237 ml can of Jevity 1.2, LPN # 5 looked at the surveyor and said, "I don't have my stethoscope, I did not check for bowel sounds."

Review of the facility policy titled "Care of the Patient with a Feeding Tube," furnished by the

F 322

be completed to include:
a. Appropriate technique for feeding tube placement check before the administration of medication or feeding.
4. DON/Unit Managers/Designee will complete med pass on feeding tube patients weekly for one month, then monthly for two months, then quarterly for two more quarters to ascertain nursesl completion of feeding tube placement check prior to med/feeding administration. Any deviation will be forwarded to the QA committee for resolution/recommendation..

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Director of Nursing (DON), revealed the following under the section "Procedure: General Principles related to Enteral Feeding:"

"5. Verify placement of feeding tube PRIOR (sic) to infusion of formula...."

The policy also notes the following under the section "Procedure: Medication Administration"

"4. Verify tube placement and residual amounts."

Interviewed after the completion of the medication pass and pour for Resident# 20, LPN # 5 admitted that he did not check the placement of the feeding tube and did not check for feeding tube residual.

2. For Resident # 21, facility staff failed to correctly check the placement of a feeding tube prior to the administration of medications and tube feeding.

Resident# 21 in the survey sample, an 88 year-old male, was admitted to the facility on 2/10/16 with diagnoses that included bilateral pneumonia, mononeuropathy, hypertension, contractures, dementia, dysphagia, depressive disorder, seizures, and PEG (Percutaneous Endoscopic Gastrostomy) tube placement. According to the most recent Quarterly MOS, with an ARD of 6/21/16, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 00 out of 15.

Resident # 21 had the following order for feeding, dated 6/27/16, "Enteral feed order every shift for nutrition Jevity 1.2 @ 60ml/hr (60 milliliters per

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F 322	Continued From page 75 hour) x (times) 24 hours via GT (g-tube)." During the medication pass and pour observation at 9:50 a.m. on 6/28/16, LPN# 5 stopped the tube feeding pump and disconnected the feeding supply tube from the feeding tube. Prior to the administration of medications through the feeding tube, LPN # 5 took a large bore feeding syringe, and while listening to the resident's abdomen with a stethoscope, injected air into the feeding tube. LPN # 5 then administered five medications through the feeding tube, after which he reconnected the feeding tube to the feeding tube pump. The facility policy titled "Care of the Patient with a Feeding Tube," notes the following under the section "Procedure: Verification of Feeding Tube Placement:" "1. Correct placement of a feeding tube will be checked by aspiration of gastric contents and auscultation immediately prior to the administration of any water flush, prescribed medication and nutritional feedings via the enteral route. (Auscultation of air as the sole determinant of feeding tube placement is no longer considered the best method of verifying tube placement.)" During an end of day meeting with the facility's administrative staff and the survey team at 3:30 p.m. on 6/28/16, the DON confirmed that auscultation (injection of air) was not the preferred method of verifying feeding tube placement.	F 322		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 3231		8/1/16

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F 323!

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, resident interview, family interview, and facility document review the facility staff failed to ensure a safe smoking environment for three of 34 residents in the survey sample: Residents# 19, 11, and 33. For Residents, #19, 11, this resulted in the identification of Immediate Jeopardy and Substandard quality of care. The facility administration was notified of the finding of Immediate Jeopardy on 6/29/16 at 6:30 p.m. Following the presentation and acceptance of a Plan of Removal, the finding of Immediate Jeopardy was removed 6/30/16 at 8:15 p.m. Subsequently, the deficiency was assigned a scope and severity of Level 2, isolated.

1. The facility staff failed to implement safety measures for Resident # 19, a resident with known seizure activity. Resident # 19 was not reassessed for safety and the facility failed to follow the policy for safety by allowing him to keep his lighter at the bedside.

2. Resident #11, with severely impaired cognitive skills and a care plan requirement for supervised smoking, was allowed to smoke unsupervised. After exhibiting increased exit seeking behavior

F323 Cross Reference to 12 VAC
,' 5-371-140 (A) and 12 VAC 5-371-220 (A)
1. Resident# 19 transferred to the hospital on 7/10/2016 and went home
¡ thereafter. Resident #11 placed on supervised smoking, provided with smoking apron, wander guard removed as per court appointed guardianI s request. Resident #33 smoking
, assessment completed on 6/24/2016 and also reviewed on 6/29/2016
2. Reassessment of all active smokers
, will be completed to determine their competency for unsupervised smoking and develop appropriate documented safety measures as may be applicable.
3. Re-education of the staff and active smokers on the following:
a) Smoking policy
b) Daily protocols (storage of lighters, storage of cigarette for all those requiring supervision, etc.)
c) Staff monitoring of policy adherence
d) Care planning of smokers who are assessed for needing supervision and scheduled smoking time
e) Smoking assessment on

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and placement of a Wanderguard safety device, Resident #11 was allowed out of the facility unsupervised without a plan of care for outside safety.

3. Resident #33 was identified as a smoker by the facility on 05/31/2016. An assessment to determine whether or not Resident #33 was safe to smoke without supervision was not conducted until 06/24/2016.

Findings include:

1. Resident# 19 was allowed to smoke outside the facility, unsupervised, after having documented seizure activity while smoking. The facility did not put safety interventions in place for Resident # 19, and did not reassess his ability to safely smoke.

Resident# 19 was initially admitted to the facility 4/18/15 with a readmission date of 5/25/16. Diagnoses for Resident# 19 included, but were not limited to: epileptic seizures, COPO, GERO, depression, difficulty walking, asthma, schizoaffective disorder-bipolar type, irritable bowel syndrome, and unspecified psychosis.

The most recent MOS (minimum data set) was a : quarterly review dated 6/1/16 and had the resident as being cognitively intact with a total summary score of 15 out of 15.

The electronic medical record (EMR) was reviewed 6/29/16 at 9:00 a.m. Nursing notes documented the following:

4/8/16 06:28(6:28 a.m.) "Writer reported to work at 05:45 [5:45 a.m.] and met [name of resident]

F 323!

admission/readmission and as needed
i f) Signing of the Patient Smoking Acknowledgement
4. The Administrator and/or the **OON/AOON/UMs** will audit the medical records of all current- patients who are active smokers to ensure that necessary safety intervention has been put in place and is being implemented weekly for one month, then monthly for two months, then quarterly for two more quarters. Any deviations will be forwarded to the QA committee for resolution.

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sitting outside the main entrance smoking. Writer witness [sic] same situation Tuesday 4/5/16 and resident was educated to wait until secretary at lobby to *activate* door to 'open' so he can be seen by staff. Resident also educated on risk of having a seizure when he is alone with no staff member around. Writer asked resident how he got out and he stated he wait at the lobby for phlebotomist or delivery people coming in and out and also leave and enter. Writer again educated resident about his frequent seizure activity and risk of having seizure with no staff around due to his noncompliance with the facility smoking rules. , **He verbalized understanding of the risk."**

4/19/16 15:46 (3:46 p.m.)- "....writer and staffs [sic] responded to resident having seizure while smoking downstairs...."

4/19/16 18:30 (6:30 p.m.)- "DON [director of nursing] and charge nurse met with resident to discuss resident's noncompliance with leaving the unit unsupervised due to frequent recurrent seizure activity and associated risks. Resident was offered to have staff accompany him to the patio when he leaves that unit but he declined. Resident waits by the main entrance doors during odd hours and sneaks [out] when someone unfamiliar open the door and when redirected he get agitated [sic]. ADT (administrative disciplinary team] suggested setting specific times for staff to supervise resident when he is off unit for seizure activities. Resident staunchly declined staff supervision. He did not want to hear about setting specific times for staff to accompany him from the unit to the patio so that he can know when to anticipate staff assistance. he states he wishes to be left alone. He further stated he will leave the unit and go outside anytime he.."damn

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well pleases. I just don't go there to smoke. I want to hang out with my friends and I don't need anybody watching me." Resident's cognitive skills for daily decision making is very intact. He is capable of making an informed educated decision but has chosen to be noncompliant with medical safety interventions. Resident has been educated on the disease process, safety, that his noncompliance is placing him at a very high risk for injuries that may even result in death and he has staunchly chosen not to understand or comply. Resident is self RP [responsible party]. NP [nurse practitioner] visiting facility was notified."

4/28/16- "Seizure while smoking....."

6/21/16- "Seizure lasting 10 minutes....educated re seizure precautions...."

The current comprehensive care plan (CCP) was then reviewed. Under "Focus" was documented "Resident is a smoker" The date the CCP was created was dated 5/21/15 with a revised date of 5/23/16. Under "Goals" was documented "The resident will not suffer injury from unsafe smoking practices through the next review." Under "Interventions" was documented "Instruct resident, about smoking hazards and about smoking cessation. Instruct resident about the facility policy on smoking: locations, times, safety concerns. Notify charge nurse immediately if it is suspected resident has violated smoking policy. The resident can smoke UNSUPERVISED [sic]. The resident is able to safely light own cigarette and may keep lighter at bedside." The CCP did not include any interventions to reflect the need for supervision while smoking due to seizure activity or the resident's behavior of sneaking out

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during odd hours.

The safe smoking assessment was reviewed. The assessment was dated 4/29/15 and had Resident # 19 assessed as needing no supervision to smoke.

On 6/29/16 at 11:30 a.m. the administrator was asked about the frequency of the smoking assessments. The administrator stated he would check on that and get back to me. At 12:50 p.m. the administrator told this surveyor "There is no set frequency for when to do an assessment for smoking, just as determined by the IDT [interdisciplinary team]."

On 6/29/16 beginning at 4:25 p.m. during a meeting with facility staff, the administrator and DON were informed of the above findings. They were asked since Resident # 19 had been witnessed to leave the facility at odd hours by waiting by the door, and having had seizure activity while smoking, should the CCP be updated about those items, and should a smoking assessment be done to ensure the resident was still safe to smoke unsupervised? The DON was also asked how staff were to be aware of the resident's behavior if the plan of care did not address it. The administrator stated "The residents who are cognitive and the **smoking assessment indicates they are safe to** smoke unsupervised are allowed to do so. I don't know about the CCP; it's documented that there was a conversation with the resident about putting safety measures in place and he refused. If he is willing to accept the risks I'm not sure we can make him. [...]he has rights. I can't just discharge someone for not following smoking rules." The facility policy for smoking was

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requested from the administrator at that time.

The policy titled "Patient Smoking" was received and reviewed. The policy documented "The Center promotes a smoke-free environment to protect the health, safety and well-being of all our patients; therefore the Center maintains a policy of no smoking within the building by anyone at any time." (Bold letters by policy writing).

Under "Procedure" was documented:
"1. The Administrator may or may not choose to designate areas outside the building for any smoking activities."

"3. A patient may smoke in designated smoking areas that may be established on the grounds of the Center: a. if the patient has been assessed by the interdisciplinary team, and b. it has been determined through the Safe Smoking Assessment that it is safe for the patient to smoke."

"4. If a smoking area is administratively designated on the grounds of the Center, any patient who wishes to smoke will be evaluated (see Safe Smoking Assessment) by the Interdisciplinary Team upon admission to determine safety and ability to handle smoking material. The patient must also sign the Patient Smoking Acknowledgement form which is to be maintained in the patient's medical record.

If supervision is deemed necessary the patient will be supervised by staff or other appropriate person (i.e. family member) and with any safety device needed(i.e. smoking apron).

Ashtrays of noncombustible material and safe

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design shall be provided.....

A smoking schedule will be created for patients requiring supervision.

All instruments that cause a spark or flame (igniting products) will be kept in a locked location.

Smoking is only allowed in designated outside smoking areas and where oxygen is not being used or stored.

Sharing of smoking material with patients by patients, staff, family members or other visitors is strictly prohibited."

"5. Failure to comply with the use of any smoking and/or igniting products may result in the initiation of the discharge process."

The administrator, DON, and corporate nurse consultant were informed of the finding of Immediate Jeopardy 6/29/16 at 6:30 p.m.

The administrator presented the survey team with a five point plan for the removal of Immediate Jeopardy 6/29/16 at approximately 8:00 p.m. which included: the smoking area placed on immediate supervision until individualized care plans were developed to provide a safe smoking environment for all active smokers. Per policy all lighters and matches currently in patients' possession will be collected by staff and stored in a locked location. Active smokers would be reassessed to determine competence to smoke unsupervised and develop appropriate safety measures. Re-education of staff and active smokers on the smoking policy, daily protocols on

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the storage of lighters for those needing supervision, staff monitoring for policy adherence, care planning for smokers assessed to need supervision and scheduled smoking time, and signing of the "Patient Smoking Acknowledgement." Administrator and staff will audit Residents 11 and 19 to ensure safety interventions in place. Date of compliance 6/29/16.

The survey team, after review of the plan of removal, accepted and removed the Immediate Jeopardy 6/29/16 at 8:15 p.m.

On 6/30/16 at 8:00 a.m. the safe smoking reassessment for Resident# 19, and an updated care plan, was provided by the administrator. The safe smoking reassessment dated 6/29/16 revealed the resident was assessed as needing a smoking apron and supervision. The smoking assessment also documented "Resident has diagnosis of seizure disorder and so has potential to seize while smoking. Resident will be provided a smoking apron when smoking as a safety precaution." The CCP was updated to include the safety precautions and supervision for Resident# 19. The signed "Patient Smoking Acknowledgement" form was also provided. The form was dated 6/29/16. The administrator stated "We couldn't locate all the signed forms; some of the residents have been here for 10 years or more. We just went ahead and had them signed last night."

On 6/30/16 at approximately 9:15 a.m. this surveyor went to the smoking area per the reassessment of Resident# 19, and the smoking schedule developed for him. Resident# 19 was sitting in his wheelchair, smoking, without the

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smoking apron on his person as the smoking assessment documented he would have. This surveyor asked Resident # 19 if he was aware he was to have the smoking apron on, and he stated : " Yes. " Resident# 19 was then asked if he had a smoking apron, and he reached down to the side of the wheelchair and held up a folded, unused apron. This surveyor then asked if he was going to put it on, and he began unfolding the apron, and attempted to put the apron on. A staff member, who was standing a few feet away, came over and began helping Resident# 19 put the apron on. Resident# 19 voiced his disagreement to wearing the apron, to which the staff member told him "This is to make sure you are safe. "

A few moments later, this surveyor spoke to the staff person, whq stated she worked in the business office, and since she occasionally smoked, had agreed to be one of the staff who supervised the smoking area. The staff member was asked if she was aware Resident # 19 was to wear the smoking apron, and asked why the resident did not have it on while smoking. The staff member stated "The DON came out earlier and put one on him; I think he must have taken it off .... " The staff member was then made aware the apron the resident presented to this surveyor had been unused, and folded with the tie strings still tied around it. The staff member then stated " I tried to encourage him to put it on; I guess he must have gotten another one ..... " During that time, the administrator had walked over and was standing beside the staff member as this surveyor was interviewing her. The administrator stated " [name of resident] is somewhat anti-authority. He has stated he does not want to wear the apron, and has signed a statement. "

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The administrator then handed this surveyor a copy of a paper with a paragraph that included the resident accepted all liability for any harm that may occur as a result of not complying with the smoking rules. The paper was signed by the resident and the administrator dated 6/30/16. The resident, as noted above, had signed the " Patient Smoking Acknowledgement " form 6/29/16, as required by the facility policy, that he would comply with the smoking rules, or his smoking privileges could be suspended, and the discharge process started.

2. Resident #11, with severely impaired cognitive skills and a care plan requirement for supervised smoking, was allowed to smoke unsupervised. After exhibiting increased exit seeking behavior and placement of a Wanderguard safety device, Resident #11 was allowed out of the facility unsupervised without a plan of care for outside safety.

Resident #11 was admitted to the facility on 3/30/15 with a re-admission on 4/24/16. Diagnoses for Resident #11 included traumatic brain injury, epilepsy, cerebrovascular disease, aphasia, anorexia, anxiety, major depressive disorder, neuropathy and anemia. The minimum data set (MOS) dated 6/8/16 assessed Resident #11 with severely impaired cognitive skills and functional limitation in range of motion of his upper and lower extremities on one side.

On 6/28/16 at 10:40 a.m. an interview about quality of life in the facility was conducted with the resident's guardian. The guardian stated she

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routinely visited and spent time with Resident #11 daily but was unable to visit during several weeks . in May (2016) due to illness. The guardian stated · she was "just coming back" to the facility after being sick. The guardian stated when she was unable to visit in May 2016 a Wanderguard device was placed on Resident #11's wheelchair causing the door to alarm when Resident #11 attempted to go outside. The guardian stated she. accompanied the resident outside during her visits and was concerned that staff members did not take Resident #11 outside when she was unable to visit. The guardian stated the resident routinely smoked in the designated smoking area and she did not understand why the resident had ! the Wanderguard.

· Resident #11's clinical record was reviewed on 6/28/16. The clinical record documented the following about smoking.

9/11/15 - "Patient is non compliance with smoking. Writer spoke to patient's guardian...regarding the medical disadvantage of smoking especially his head injury. Guardian stated that [Resident #11] has been smoking through out his life and no body will stop him smoking..." (sic)

9/14/15 - "...DON [director of nursing] and writer explained the adverse effects of smoking and wound healing to guardian. The guardian said he does not matter the medical problems patient may have, he is fine for him to smoke...So she [guardian] authorized two alert and oriented residents to assist patient with smoking when staff are not around. She will provide cigarettes..." (sic)

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F 323	Continued From page 87 1/18/16 - "At around 1930 [7:30 p.m.] resident insisted to go out by himself to smoke. Writer explain to resident he cant [can't] go out by himself and need an escort. Resident got upset and started striking the walls, and his head. Resident family was notified. Resident [Guardian]...stated 'resident can go out and smoke by himself with no escort needed'." A smoking assessment dated 3/29/16 listed the resident was safe to smoke without supervision, or safety devices. A "Smoking - Safety Screen" for Resident #11 dated 3/29/16 listed the resident had cognitive loss, had dexterity problems, smoked 2 to 5 cigarettes per day and liked to smoke in the morning, afternoon and evening. This assessment stated Resident #11 was able to light his cigarettes, required no apron, no cigarette holder, no supervision or orie to one assistance for smoking. In addition, this assessment documented the resident was safe to keep his own lighter and cigarettes. This assessment documented, "At this time resident is deemed a safe smoker and so will not need no protective equipment for his safety or other residents' safety..." (sic) Resident #11's care plan (revised 5/27/16) listed the resident was a smoker. On 5/25/16 the care plan was updated requiring supervision with smoking. The care plan stated, "Resident is a smoker." The care plan goal regarding smoking stated, "Resident will not smoke without supervision through the review date." Care plan interventions for smoking stated, "Instruct resident about smoking risks and hazards and about smoking cessation aids that are available...Instruct resident about the facility policy on smoking: locations, times, safety	F 323:		

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concerns...Notify charge nurse immediately if it is , suspected resident has violated facility smoking policy...Observe clothing and skin for signs of cigarette burns...Resident requires SUPERVISION while smoking."

The clinical record documented a physician's order dated 6/15/16 for a Wanderguard device secured to the right side of Resident #11's wheelchair due to exit seeking behavior.

Resident #11's care plan included no interventions regarding who was responsible to supervise the resident during smoking. The care plan made no mention of the resident's use of the Wanderguard device or of any problems or safety concerns about the resident going outside unsupervised. There were no revisions to the care plan regarding the resident's documented non-compliance with smoking supervision. The care plan documented the resident had poor safety awareness, impaired cognitive function due to traumatic brain injury, impulsive behavior, adverse behaviors that included scratching and removing wound dressings, cursing, hitting and kicking staff and refusal of care. The care plan also documented the resident had communication problems due to speech impairment from a stroke.

Resident #11's clinical record documented the resident had a history of falls, was non-compliant with care and was at times combative with staff and was self-injurious. Nursing notes for May and through 6/27/16 documented the following.

5/9/16 - "Resident was found on the floor mat in his room...Resident had an actual fall and at risk for further falls r/t [due to] poor safety awareness,

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confusion and impulsive behavior secondary to TBI [traumatic brain injury]"
5/12/16 - "...Resident has history of falls. Resident has contracture of his left arm. Resident is unable to bend his left leg. Resident has history of accident and sustained head injury. Resident has history of seizures. Resident is unable to talk but utters sounds when he needs assistance...Resident exhibits adverse behavioral symptoms namely: Intensely scratching and removing dressing on scalp wound, cursing, hitting, kicking staff, and refusing to be changed..."

5/15/16 - "...While in the dining room resident was observed trying to hit the sister..."

5/16/16 - "Resident was observed trying to go [to] the bathroom on his own. Resident lost his balance and fell on the floor..."

5/22/15 - "Resident behavior is very alarming this morning. As care team was attempting to provide care to resident he started kicking and swearing curse words as well as trying to punch staff. We attempted again to get resident cleaned up from urine accident and he ripped the diaper off and slung it at staff. We immediately left the room before anyone got hurt..."
5/23/16 - "...Resident easily becomes angry. At first he did not want staff to remove his shoes. Resident started to hit his head..."

5/26/16 - "During review period resident exhibited increased agitation and aggression as evidenced by hitting and kicking staff and hitting himself in the head..."

5/27/16 - "...Resident is non-compliant with care.

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. Resident was incontinent of urine this am [morning) and refused to be changed..."

5/31/16 - "...Resident was not observed but he states he was pointing at his breakfast tray that was left in his room so it seems like he was trying to reach his tray to eat breakfast in the process lost his balance..."

6/14/16 - "...Resident is very non compliant with keeping dressing on. Removes dressing and picks on wound..."

6/16/16 - "...Resident continues to remove dressing on scalp and picking on wound..."

6/17/16 - "...Resident continues to remove dressing on scalp and picking on wound..."

On 6/28/16 at 1:45 p.m. the facility's activity director was interviewed about Resident #11. The activity director stated Resident #11 routinely went outside and smoked in the designated smoking area without supervision. The activity director stated Resident #11 went outside and "there was not always a staff person assigned." The activity director stated the resident liked to sit on the walk near the front entrance and spend time in the designated smoking area. The activity director stated she felt Resident #11's going outside and smoking unsupervised was not safe. The activity director stated the entire smoking area was unsafe because there was no routine supervision of residents smoking. The activity director stated Resident #11 had a Wanderguard placed when his family member was unable to routinely visit and the resident had increasing behaviors of leaving the facility. The activity director stated with the Wanderguard the front

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entrance door alarmed when Resident #11 approached to exit but that the front desk receptionist "deactivated" the alarm and let Resident #11 outside. The activity director stated if the resident went out of the front door to the left toward the main highway, the front desk receptionist went after the resident and re-directed him. The activity director stated the resident was allowed to go out the door to the right toward the smoking area unsupervised. The activity director stated Resident #11 was usually accompanied to the smoking area by Resident #19. The activity director stated concerning going outside with activity staff, "I'm not taking him [Resident #11] out." The activity director stated when volunteers were available some residents were accompanied outside but Resident #11 had not been included in out$ide activities. The activity director stated she felt the entire smoking area was unsafe because there was no scheduled supervision of the area or the residents.

On 6/28/16 at 2:05 p.m. the designated smoking was observed. The smoking area was located under an awning at the one end of the building accessible from the main parking lot. The smoking area was not visible from the front lobby or reception desk. The area was accessible from the front sidewalk area, front parking lot and a side entrance into the building. There were four residents in the smoking area at the time of this observation. Two of the four residents were actively smoking. One resident was sitting on a bench with a cigarette lighter in her hand. There were no staff members present and no protective aprons in use.

On 6/28/16 at 2:15 p.m. the licensed practical

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nurse (LPN #3) that routinely cared for Resident #11 and completed the smoking assessment dated 3/29/16 was interviewed. LPN #3 stated the assessment on 3/29/16 listed the resident as safe to smoke without supervision. When asked how the resident was assessed as safe to smoke without supervision when he had severely impaired cognitive skills, LPN #3 stated the guardian usually went with the resident outside. LPN #3 stated the resident had developed exit seeking behaviors during the last several weeks when his guardian was sick and no longer visited daily. LPN #3 stated the Wanderguard was placed on the resident's wheelchair because it was unsafe for the resident to go out toward the garden and highway unsupervised. LPN #3 stated, "We [staff] were afraid he was going farther." LPN #3 stated prior to the guardian's illness, the resident had been going outside frequently with the guardian, his cousins and sometimes a therapy aide. LPN #3 stated when the guardian was unable to visit each day the resident made increased attempts to go out alone. When asked how the resident went out of the facility with a Wanderguard device in use, LPN #3 stated the alarm was turned off. When asked how she was sure the resident was supervised when he went out to smoke, LPN #3 had no response. LPN #3 stated the nurses and unit manager were responsible for updating care plans.

On 6/28/16 at 2:30 p.m. the registered nurse unit manager (RN #5) was interviewed about Resident #11 smoking and going outside without supervision. RN #5 stated Resident #11 was "not supposed to be by himself' when smoking. RN #5 stated prior to guardian's illness, the guardian routinely went out with the resident to smoke. **RN**

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#5 stated when the guardian became sick and did not visit each day Resident #11 became more agitated and exit seeking. RN #5 stated the Wanderguard device was placed on the resident's wheelchair to prevent him from leaving the facility without staff knowledge. RN #5 stated the receptionist called him from the lobby when Resident #11 was attempting to leave the building and he would go or send staff to redirect or supervise the resident. When asked if he was aware the receptionist was turning off the Wanderguard alarm and allowing Resident #11 to go outside and smoke unsupervised, **RN** #5 stated, "No." When asked about the assessment on 3/29/16 that listed the resident as safe to smoke without supervision, RN #5 stated that assessment was wrong. RN #5 stated the resident had severely impaired cognitive abilities due to his brain injury and required supervision. RN #5 stated the current care plan was correct and the resident required supervision to smoke.

On 6/28/16 at 2:40 p.m. the front desk receptionist was interviewed about Resident #11. The receptionist stated that Resident #11 sometimes went out of the facility with Resident #19. When asked how Resident #11 went out of the facility with the Wanderguard device in place, the receptionist stated she "deactivated" the alarm by swiping her card so Resident #11 could go outside. The receptionist stated she sometimes let Resident #11 sit out on the front walk. The receptionist stated, "I eyeball him from in here." The receptionist stated if she saw Resident #11 going left toward the highway she would get him or alert other staff members. The receptionist stated sometimes a staff member went with Resident #11 outside and other times the resident went out with Resident #19. When

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asked if Resident #11 went to the smoking area supervised, the receptionist stated, "Not always." The receptionist stated she deactivated the Wanderguard alarm and allowed Resident #11 to go out of the front door toward the smoking area. The receptionist stated Resident #19 usually accompanied Resident #11 to smoke. The receptionist stated the smoking area was not visible from her desk but that Resident #11 was usually with Resident #19 when he went to smoke. While being interviewed the receptionist answered the telephone switchboard for the facility and greeted and interacted with visitors and residents from behind the front desk.

On 6/28/16 at 3:30 p.m. the administrator, nurse consultant and director of nursing (DON) were interviewed about Resident #11 smoking unsupervised when his plan of care required supervision. The administrator stated when the resident was first admitted to the facility the guardian did not want the resident to smoke. The administrator stated the resident enjoyed going outside and wanted to be with other young smokers so a plan was initiated regarding smoking.

The nurse consultant stated when the resident originally started smoking he was able to smoke safely. The nurse consultant stated recently the resident had increased behaviors and was considered a "possible danger." The nurse consultant stated Resident #11 had declined in condition and there was "maybe a need to supervise, to watch him from a distance."

The DON stated the Wanderguard was added because Resident #11 was trying to go outside alone. The DON stated sometimes the resident

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would sit safely near the front entrance and sometimes he attempted to go toward the street. The DON stated the front desk receptionist watched the resident when he went outside.

When asked how the resident was supervised when smoking as the smoking area was not visible from the lobby or front desk, the administrator stated the resident's guardian was "ok" with him going outside and smoking unsupervised. When asked why the resident was allowed to smoke unsupervised when he was assessed with severely impaired cognitive skills, had a history of falls, impulsive behaviors and non-compliance with care, the administrator stated the guardian was willing to accept the risks of Resident #11 smoking unattended.

On 6/29/16 at 4:40 p.m. the administrator was interviewed about Resident #11 smoking and going outside unsupervised. The administrator stated it was "most appropriate" for Resident #11 to be a supervised smoker but the guardian wanted the resident to be allowed to smoke. When asked about the resident's care plan that made no mention of interventions allowing the resident to smoke unsupervised or the use of the Wanderguard, the administrator stated the care plan needed to be updated. The administrator stated the Wanderguard alarm was to alert staff the resident was going outside. The administrator stated when Resident #11 went outside the front desk receptionist alerted staff if he was going toward the main highway. The administrator stated, "The front desk person is monitoring that [going outside]." The administrator stated the resident was allowed to smoke unsupervised because they were trying to maximize the resident's freedom and honor the

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guardian's wishes for the resident to go outside and smoke independently. When asked why the ' plan of care made no mention of the Wanderguard, unsupervised smoking or the receptionist's monitoring of the resident, the administrator stated, "When the ID [interdisciplinary] team figures out how to handle , this we need to update the care plan." Concerning the unsupervised smoking, the administrator stated, "We want to honor the guardian's decision to willingly accept the risks [of unsupervised smoking]." The administrator stated there were no designated smoking times in , the facility and residents were allowed to smoke in the smoking area from 8:00 a.m. until 10:00 p.m. each day.

The facility's policy titled Patient Smoking (effective 2/1/15) documented, "A patient may smoke in designated smoking area that may be established on the grounds of the Center: a. if the patient has been assessed by the interdisciplinary · team, and b. it has been determined through the Safe Smoking Assessment that it is safe for the ' patient to smoke...any patient who wishes to smoke will be evaluated (see Safe Smoking Assessment) by the Interdisciplinary Team upon admission to determine safety and ability to handle smoking material. The patient must also sign the [corporation] Patient Smoking Acknowledgement form which is to be maintained in the patient's medical record. If supervision is deemed necessary the patient will be supervised by staff or other appropriate person (i.e., family member) and with any safety devices needed (i.e., smoking apron)...A smoking schedule will be created for patients requiring supervision. All instruments that cause a spark or a flame (igniting products) will be kept in a locked

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location...Failure to comply with the use of any smoking and/or igniting products may result in the initiation of the discharge process."

Resident #11's care plan (revised 5/27/16) made no mention of any exit seeking behaviors or increased agitation related to the change in visitation by the guardian. Resident #11's nursing notes during May 2016 made no mention of the resident's exit seeking behavior, use of the Wanderguard device, or any supervision plan regarding the resident's smoking. After Resident #11's care plan was revised on 5/25/16 with the requirement for supervised smoking, there was no smoking schedule developed or *staff* assigned to provide supervision for Resident #11. There was no care plan developed regarding the resident's non-compliance with supervised smoking. There was no evidence of notification to the physician regarding Resident #11's failure to follow the facility's smoking policies. Resident #11 had no signed [corporation] Patient Smoking Acknowledgement of the facility's safe smoking rules as required in the facility's smoking policy.

These findings were reviewed with the administrator, director of nursing and nurse consultant on 6/29/16 at 4:15 p.m.

On 6/30/16 at 8:05 a.m. the administrator was interviewed about any a Patient Smoking Acknowledgement form signed by Resident #11 as required in their smoking policy. The administrator stated this form could have been in old records but he did not go back through the records to retrieve them. For Resident #11, the administrator stated he was waiting for the resident's guardian to come in and sign the acknowledgement of the safe smoking rules.

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3. Resident #33 was identified as a smoker by the facility on 05/31/2016. An assessment to determine whether or not Resident #33 was safe to smoke without supervision was not conducted until 06/24/2016.

Findings were:

Resident #33 was added to the survey sample based on the identification of immediate jeopardy with resulting substandard quality of care related to the facility's failure to provide a safe smoking environment. A copy of all smokers in the facility was requested. Resident #33 was on the list provided.

Resident #33 was originally admitted to the facility on 04/23/2016 and was most recently readmitted on 05/31/2016. Her diagnoses included but were not limited to: Joint replacement, hypertension, DVT (deep vein thrombosis), edema, epilepsy, and hypothyroidism.

The most recent MOS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/07/2016. Resident #33 was ' assessed as having a cognitive summary score of "14", indicating she was cognitively intact.

The clinical record was reviewed on 06/29. Documentation in the clinical record included two "Admission Assessment/Screening-Nursing" forms. This form was used by the facility to assess/reassess a resident at the time of admission or readmission to the facility. The form was a complete assessment of the resident' s

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status including but not limited to: Allergies, diagnoses, admission details, demographic information, orientation and neurological status, vital signs, mood, pain scale, pressure ulcer risk., etc. Included in the questions asked was: " SOCIAL HISTORY/LIFESTYLE CONERNS: ...Uses Tobacco/Smoker". Choices for this question were: " Current smoker, Past smoker, Never Smoked, UTD[unable to determine]/No response " . On the first admission assessment dated 04/23/2016 Resident #33 was assessed as a nonsmoker, "Never smoked". After being discharged to the hospital and readmitted on 05/31/2016, a second assessment was completed. Resident #33 was assessed as "Current smoker". Also observed in the clinical record was a " Smoking-Safety Screen " dated 06/24/2016 which assessed Resident #33' s ability to smoke safely. Information on that form included, but was not limited to: Cognitive status, vision, dexterity, smoking frequency, ability to light cigarettes, and time of day the resident preferred to smoke. The " Smoking -Safety Screen" determined that Resident #33 was safe to smoke without supervision. However, the " Smoking-Safety Screen" was not completed until 25 days after it was determined that Resident #33 was a current smoker and per the screening smoked "5-10" cigarettes per day and liked to smoke " Morning, Afternoon, and Evening".

Nurses notes were reviewed. The following entries were observed:
"6/3/2016 21:34 [9:34 p.m.] ...patient was observed going out to smoke X [times] 4 during this shift..."
"6/4/2016 12:22 [p.m.] ...Resident was observed going outside to smoke X 5"

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"6/6/2016 14:12 [2:12 p.m.]...Resident was observed going outside to smoke X 3."
"6/20/2016 23:01 [11:01 p.m.] ...resident is very noncompliant she continues to go outside frequently to smoke..."
"6/23/2016 13:10 [1:10 p.m.] ...patient is non-compliance [sic] and keeps on going down stairs to smoke.."

Immediate jeopardy was identified at the facility on 06/29/2016 related to smoking safety. Part of the plan of removal for the immediate jeopardy was that all current smokers would be reassessed by the facility to determine if they were safe to smoke. On 06/30/2016 upon the survey team' s entry into the facility, the administrator presented updated smoking screens on all smokers in the facility, as well as "Patient Smoking Acknowledgment" forms. A new " Smoking -Safety Screen" was completed on Resident #33. She was determined to be a " Safe Smoker" .

" On 06/30/2016 at approximately 8:00 a.m., the unit manager, RN (registered nurse) #1 was interviewed. He was asked about the discrepancies between two "Admission Assessment/Screening -Nursing" forms contained in the clinical record. One "Admission Assessment/Screening" was completed on 4/23/2016 (first admission) and the second was completed on 05/31/2016 (readmission post hospitalization). The first admission assessment determined that Resident #33 was a non-smoker. The box "Never smoked" was checked on the assessment. The second assessment determined that Resident #33 was a "Current Smoker" . The unit manage was asked when residents w o were determined to be smokers

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were assessed to determine if they could smoke with or without staff supervision. He stated, "The resident was very sick at first. Her mother gave us her initial information...The mother said she didn't smoke...the second admission the information was from the resident...she said she was a smoker...I don't know why the [smoking safety screen] assessment was not done until the 24th...I will look at the information and get back to you."

Resident #33 was interviewed on 06/30/2016 at approximately 8:40 a.m. Resident #33 was asked if she was a smoker. She stated, "Yes." She was asked how long she had been going downstairs to smoke. She stated, "The first few days that I was here I was too sick to go smoke, but after that I've been going down there everyday."Resident #33 was asked to clarify if that was since her first admission or just since her most recent admission in May. She stated, "No, since the very first time I came in, I was just too sick the first couple of days...I need to quit, the doctor wants me to quit because of my blood clots but I haven't yet." Resident #33 was asked if she had her cigarettes and her lighter in her room. She stated, "I did until last night...they [facility staff] came in here and asked me for them...they said I could have them whenever I wanted them but I have to ask...I don't mind I understand there are rules." Resident #33 was asked if her mother was aware that she was a smoker. She laughed and stated, "Yes."

At approximately 9:10 a.m. the DON (director of nursing) and the unit manager, RN #1 came to the conference room to speak with this surveyor. The unit manager stated, "There was a conflict between what the mother told us and the resident

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F 323	Continued From page 102 told us...we were trending the information to see if: she was really a smoker before we did the assessment." The DON stated, "Sometimes they go downstairs to socialize and not smoke...we were waiting to see if she was really smoking." The interview this surveyor had with the resident as well as the notes preceding the original smoking assessment were shown to the DON and the unit manager. The above information was discussed in a meeting with the administrator, the DON and the regional nurse consultant on 06/30/2016. No further information was obtained prior to the exit conference on 06/30/2016.	F 323		
F 325 SS=E	, 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, facility staff failed to maintain nutritional status for one of 34 residents in the survey sample, Resident #5.	F 325!	F 345 Cross Reference to 12VAC 5-371-220 (8) and (C) (1) 1. Resident #5 ProStat ordered on 6/28/16 and administration started on	8/1/16

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Facility staff failed to reorder Prostat on Resident #S's readmission to the facility on 05/31/2016. Prostat was not reordered until 06/28/2016 and Resident #5 did not receive his first dose until 06/29/2016.

Findings included:

Resident #5 was originally admitted to the facility on 07/06/2012 and readmitted on 05/31/2016 with diagnoses including, but not limited to: Hepatitis-C, Parkinson's Disease, Seizures, Encephalopathy, Sepsis, Dysphagia, Psychosis, Anxiety, Hypertension, Schizophrenia, Protein-Calorie Malnutrition and Dehydration.

The most recent MOS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 05/19/2016. Resident #5 was assessed as severely impaired in his cognitive skills with a total cognitive score of three out of 15.

Review of Resident #S's clinical record was conducted on 06/28/2016 at 9:00 a.m. A "Nutrition/Dietary Note" dated "6/1/2016" included the following documentation by the RD (registered dietitian), Other #1: "...Nutrition Diagnosis (D) Inadequate protein-energy intake...protein currently only providing 1.1 g/kg (gram per kilogram] IBW [ideal body weight]. Nutrition Prescription/ Interventions (I) Will add Prostat SF (sugar-free] 30 ml [milliliters] qd [everyday] via G-tube (gastrostomy]...to provide an additional 100 kcal and 15 g protein a day for a total of 107 g pro [protein]..."

The current POS (physician order sheet) dated

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6/29/16

2. Dietician to audit all current nutritional assessment of readmitted/admitted patients in last 30 days from 6/28/16 to ascertain that there are no recommended Nutritional Supplement orders not transcribed into the POS/MAR. Anomaly will be rectified accordingly.

3. Re-education of registered dietitian will be completed to include:

a. Reordering and transcribing of Nutritional Supplement for readmitted patients as applicable.

b. Communicating dietary recommendation with the nursing staff.

4. Regional Dietician/Designee will review 10% of all recent nutritional assessments to ensure that there is no missing transcription of Nutritional Supplement recommendation. This will be completed on a weekly basis for one month, then monthly for two months, then quarterly for two more quarters. Any deviations will be rectified and then forwarded to the QA committee for additional recommendation.

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06/01/2016 through 06/30/2016 included the following order: "...Dietary Supplements: Prostat : SF one time a day for Supplement 30 ml via G-tube. Order Date: 06/28/2016 Start Date: 06/29/2016.

Review of the June 2016 MAR (medication administration record) included documentation Resident #5 did not receive any Prostat until 06/29/2016.

The RD, (Other #1) was interviewed on 06/29/2016 at approximately 3:35 p.m. regarding her "Nutrition/Dietary Note" from 06/01/2016, specifically her recommendation of adding Prostat for the extra calories and protein. Other #1 stated, "I verbally relay info [recommendations] to the nurse on at the time. When I looked at his record last night (06/28/2016) I realized I did not reorder the Prostat on his last readmission and reordered today."

Corporate RD, (Administration #4) stated, "The facility has a nutrition order writing protocol that we use to write orders for recommendations. I will get you a copy of the protocol."

At approximately 3:45 p.m., Administration #4 brought a copy of the nutrition order writing protocol to this surveyor. This protocol included the following information: "Nutrition Order Writing Protocol - Protocol: The Registered Dietitian(s), or approved designee(s) are permitted by the medical review board of this center as indicated below to write orders in the medical record for medical nutrition products and diets for the purpose of enhancing residents' diet orders in order to meet assessed nutritional needs.

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F 325	Continued From page 105 Procedure: ...6. The Registered Dietitian may write or modify enteral and parenteral orders including formula type, rate, strength, and flushes...d. Add protein supplements to meet protein needs. 7. The RD, and/or approved designee(s) will write the order in the Physician Order section of the medical record, complete with signature, credentials, and date, then flag the order for the charge nurse to process." The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 06/29/2016 at approximately 4:15 p.m. No further information was received by the survey team prior to the exit conference on 06/30/2016.	F 325:		
F 329 SS=D	483.25(1) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		8/1/16

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behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

F 329

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to ensure one of 34 residents was free from unnecessary medications, Resident #6.

Resident #6 was prescribed Remeron (an antidepressant) for appetite.

Findings were:

Resident #6 was originally admitted to the facility on 08/02/2015 and was most recently readmitted on 05/05/2016. Her diagnoses included, but were not limited to: Unspecified psychosis, hypertension, dementia with behaviors, insomnia anxiety and Myelodysplastic syndrome.

The most recent MOS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 06/07/2016. Resident #6 was assessed as having a cognitive summary score of "00", indicating severe impairment with her cognitive status.

The clinical record was reviewed on 06/28/2016. The POS (physician order sheet) for June 2016 contained the following order, "Remeron 15 mg (milligrams) Give 1 tablet by mouth one time a day for appetite." There was no diagnosis listed.

F329 Cross Reference to 12 VAC 5-371-220 (B)
1. Resident #6 diagnosis for Remeron changed to depression on 6/28/2016
2. An audit of all residents with active order for Remeron will be conducted to ensure appropriate diagnosis assignment. Those not in compliance will be updated accordingly.
3. Re-education of nursing staff will be completed to include:
a. Appropriate diagnosis for Remeron.
4. The DON or designee, will audit all patients on Remeron on an ongoing basis weekly for one month, then monthly for two months, then quarterly for two more quarters to ensure the assigning of appropriate diagnosis. Any deviations will be forwarded to the QA committee for resolution.

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The start date for the medication was 05/31/2016.

According to "Nursing 2012 Drug Handbook," Remeron is an antidepressant indicated for the treatment of depression. Remeron is not indicated for use as an appetite stimulant. "Increased appetite" under GI (gastrointestinal) is listed as an adverse reaction. (1)

The administrator, the DON (director of nursing) and the regional nurse consultant were notified of the above information during a meeting on 06/28/2016 at approximately 4:00 p.m. Also discussed was that there was not a diagnosis of depression listed in the clinical record for Resident #6.

On the morning of 06/30/2016 the administrator presented a revised order written on 06/28/2016 at 18:38 (6:38 p.m.) which read: Remeron tablet 15 mg...give 1 tablet by mouth one time a day for depression." Also presented was was a geriatric psychiatry progress note date 06/23/2016 which included a notation of "Depression on Remeron stable." The administrator stated, "It is a documentation error, the medication order should have been for depression." It was pointed out to the administrator that the original order for the Remeron was dated 05/31/2016 for appetite was written almost a full month prior to the involvement and documentation on the geriatric psychiatry note that indicated that Resident #6 had a diagnosis of depression. Also pointed out was that depression was not listed in her clincal record as a diagnosis. The administrator was in agreement.

No further information was obtained prior to the exit conference on 06/30/2016.

F 329'.

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F 329	Continued From page 108	F 329!		
	(1). Lippincott Williams & Wilkins, "Nursing 2012 Drug Handbook" 32nd Edition, 2012, Ambler, PA.			
F 385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A **PHYSICIAN** A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility policy review, the facility failed for one of 34 residents in the survey sample (Resident# 34) to ensure the resident's attending physician provided medical supervision and management of the resident's care. The resident's attending physician, who was also the Co-Medical Director, failed to exercise due diligence in the management of the resident's medical care and in addressing the non-compliance of the resident's family in the provision of nursing care. The findings were: Resident# 34 in the survey sample, a 90 year-old female, was admitted to the facility on 6/12/16	F 385!	F385 Cross Reference to 12 VAC 5-371-220 (8) 1. Resident # 34 was transferred to the ER and went home thereafter on 6/30/2016 2. A review of all current patients assigned to the Co-Medical Director will be completed and any indication of treatment/medication refusal forwarded to the said physician for follow-up medical review. Any non-compliance to treatment findings to be rectified by the physician as applicable. 3. Re-education nurses and physicians will be completed on the following: a. MFA Refusal of Medication/Treatment	8/1/16

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' with diagnoses that included cellulitis, lymphedema, generalized muscle weakness, , cerebral infarction, edema, hypothyroidism, hypertension, vitamin deficiency, overactive bladder, and hyperlipidemia. According to a Medicare 14-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/26/16, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15.

The resident's attending physician failed to provide medical supervision and management of the resident's care as evidenced by:

a). Orders for the care of Resident# 34's leg wound were not obtained in a timely manner.

A thorough review of Resident# 34's Electronic Health Record (EHR) and paper clinical record failed to reveal any documentation that her legs and leg wound were assessed by the facility staff at the time of admission, or at any time prior to 6/30/16, when the legs and wound were first observed by the facility staff and the survey team.

Resident # 34's Electronic Medication Administration Record (E-MAR) included the following treatment order, dated 6/16/16, for the treatment of her leg wound, "Clean wound with N/S (Normal Saline), skin prep to peri-wound, primary dressing apply prisma AG, secondary dressing, piece of plain foam, (make sure to peel of [sic] plastic layer from back), then ABD pad if draining every day shift Mon (Monday, Wed (Wednesday), Fri (Friday) for wound care." The order for care of the leg wound was obtained four days after the resident was admitted.

F 385

Care policy
b. Physician notification of treatment/medication refusal by nurses
c. Physician follow-up on refusal of treatment/medication by the patient

' 4. The DON/Designee will audit 10% of all patients assigned to the Co-Medical Director to ensure that refusal of treatment/medication Policy has been followed weekly for one month, then monthly for two months, then quarterly for two more quarters. Any deviations will be forwarded to the QA committee for resolution.

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During an interview at 12:30 p.m. on 6/30/16, the resident's daughter said, "To my knowledge, no **one here has ever seen the wound." The** resident's daughter went on to say that, "I told the nurses I would prefer if they didn't touch the (resident's) legs. I have no orders to take her to the wound clinic. I call and make an appointment to go to the wound clinic."

At approximately 3:00 p.m. on 6/30/16, during an interview with the resident's attending physician, who also serves as the Co-Medical Director, the physician stated that he has never seen the resident's leg wound.

A thorough review of Resident # 34's EHR and paper clinical record confirmed there were no orders to seek treatment of the leg wound or lymphedema at the wound clinic.

b). Care of the resident's legs and leg wound was not provided by the facility's nursing staff.

. Resident# 34's Electronic Medication Administration Record (E-MAR) included the following order, dated 6/13/16, "Treatment - Lymphedema wraps every day shift lymphedema wraps to bilateral feet every day." The treatment order was signed off as having been performed daily from 6/13/16 through 6/30/16.

The E-MAR also included the following treatment order, dated 6/16/16 for the treatment of her leg wound, "Clean wound with N/S (Normal Saline), skin prep to peri-wound, primary dressing apply prisma AG, secondary dressing, piece of plain foam, (make sure to peel of [sic] plastic layer from back), then ABO pad if draining *every* day

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shift Mon (Monday, Wed (Wednesday), Fri (Friday) for wound care." Wound care was signed off on the E-MAR as having been performed on 6/17/16, 6/20/16, 6/22/16, 6/24/16, 6/27/16 and 6/29/16.

During an interview at 12:30 p.m. on 6/30/16, the resident's daughter said she and her sister have done the wraps and wound care several times. "I told the nurses I would prefer if they don't touch the legs," the resident's daughter said.

Review of the facility's policy "General Wound Care/Dressing Changes" noted the following:

"POLICY: A licensed nurse will provide wound care/dressing change(s) as ordered by physician."

At 1:10 p.m. on 6/30/16, two of the staff members who signed off the E-MAR as having performed the lymphedema wraps and wound care were interviewed. RN# 7 (Registered Nurse) said, "We don't do dressing changes, her daughter does them. We are not allowed to. We used to do it but we did not do it correctly."

RN # 8 stated, "We are just documenting that the dressings are intact, not that we are doing it. Sometimes I document in the Nurses Notes that the dressing is intact." RN# 8 went on to say that the Nurse Practitioner was made aware that staff is not doing dressing changes, but she (the Nurse Practitioner) did not write any new orders.

c). The resident's attending physician, who was also the Co-Medical Director, failed to exercise due diligence in addressing the non-compliance of the resident's family in the provision of nursing

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care.

At approximately 3:00 p.m. on 6/30/16, a telephone interview was conducted with the resident's attending physician, who also serves as the Co-Medical Director. The physician admitted he has never seen the resident's leg wound. He also said he did not know the resident's daughter had taken her to the wound clinic.

The physician went on to say he was aware the resident and her family were non-compliant with the treatment orders for her lymphedema and leg wound. "We talked to the family multiple times," the physician said. "If the family is going against doctor's wishes for treatment, we just accept it." The physician inferred there was not much he could do to address the family's/resident's non-compliance. Asked if he had any notes of his conversations with the resident and her family, the physician said, "I don't recall."

Review of the facility policy "Refusal of Medication/Treatment Care" noted the following:

"POLICY: A licensed nurse is to document and notify the physician and responsible party when a patient refuses medication(s) and/or treatment.

PROCEDURE: 2. Three days of patient's refusal to medication(s)/treatment/care requires the notification of the physician and responsible party. The physician will review and determine if the current drug/treatment plan is appropriate and whether discharge planning may be initiated."

F 465 483.70(h) F 465 8/1/16
SS=E SAFE/FUNCTIONAL/SANITARY/COMFORTABL

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E **ENVIRON**

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and resident interview the facility staff failed to ensure one of 2 handrails was securely affixed to the concrete at the main entrance of the facility. The handrail on the left side at the main entrance of the facility was wobbly, and four of six bases of the handrail was not secured to the concrete, causing an unsafe environment for residents, staff, and visitors who may need to use the railing for support.

Findings include:

On 6/28/16 at approximately 2:00 p.m., this surveyor was entering the building and a resident sitting in a wheelchair at the facility entrance motioned this writer over to a section of railing to the left of the entrance as I stepped onto the sidewalk. The resident then proceeded to shake the railing back and forth, and stated he had noticed the railing was not secure, and voiced his concern over safety for others. The resident was asked how long the railing had been in that condition, and he stated "Too long." The resident further stated he had told the maintenance director about the railing, but that nothing had been done to address the loose railing.

On 6/28/16 at approximately 2:20 p.m. the maintenance director was interviewed about the

F 465•

F465 Cross Reference 12 VAC
5-371-370 (A)
1. The unstable hand rail was securely fixed to the concrete on 6/30/2016.
2. Facility Director of Maintenance assessed the two front entrance handrails on 6/28/2016 to ascertain the stability. Only the reported unstable handrail was noted to be affected; which was repaired on 6/30/2016.
3. Re-education of facility maintenance staff will be completed by 7/29/16 to include:
a. Monitoring, assessment, and maintenance of handrails in and outside of facility building.
4. The Administrator/Director of maintenance will assess the front handrails to ensure it is secured on an ongoing basis weekly for one month, then monthly for two months, then quarterly for two more quarters. Any deviations will be forwarded to the QA committee for resolution.

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railing, and was asked if he was aware it was loose. The maintenance director stated he had been aware for "maybe a week." The maintenance director was then asked if a work order had been created for the railing, and if this surveyor could see it. The maintenance director then stated "I think I was made aware of the railing being loose this past Friday; I'm doing a work order today,"

On 6/28/16 at approximately 3:30 p.m., the maintenance director presented this surveyor with a copy of a work order. On the work order was included a correspondence from another staff member dated 6/13/16 at 8:54 a.m. which documented "The front railing once you leave the bldg. remains wobbly when you touch it and seems like a safety issue for a person who is actually using it to support themselves." Under the staff comments on the railing was dated 6/28/16 by the maintenance director with "Task Status: Closed- Date of completion is Jun 28, 2016 at 3:03 p.m."

On 6/29/16 at 7:30 a.m., as the survey team was entering the facility, this surveyor went over to check the stability of the hand railing and found it was still wobbly and not secured to the concrete. Upon inspection, it was observed the bases that were not attached to the concrete had nails under one side of the base in an attempt to keep the railing from being wobbly. The nails had worked themselves away from the bases, and one base completely slid over the nails causing it to be even more unsecure.

On 6/29/16 at 10:25 a.m. the staff member identified as the writer of the problem (the activity director) with the railing 6/13/16 was interviewed.

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The activity director was asked if she knew how long the railing had been loose. The activity director stated "I know I had mentioned it before 6/13/16; I don't really remember exactly how long though..... I know over the winter it had been loose because we had so much snow...."

On 6/29/16 during a meeting with facility staff beginning at 4:10 p.m., the administrator was informed of the above findings. The administrator, stated the maintenance director had told him he had fixed the railing on 6/28/16; this surveyor again told the administrator of the railing being unsecured upon entering the facility 6/29/16.

On 6/30/16 at 8:00 a.m. this surveyor observed a I welding company working on the railing. At approximately 1:00 p.m. that same day, this surveyor tested the railing and found it to be secure.

No further information was provided prior to the exit conference.

F 490 : 483.75 EFFECTIVE
SS=E : ADMINISTRATION/RESIDENT WELL-BEING

F 490 — 8/1/16

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on survey findings the facility administrator failed to provide effective administration to prevent Immediate Jeopardy

F490
1. Plan of Correction completed for both IJs on 6/29/16 and 6/30/16 and were

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leading to substandard quality of care in the area of Quality of Care.

Specifically, the administrator failed to ensure a safe smoking environment for residents identified as needing supervision and/or adaptive equipment for smoking, including enforcement of the smoking policy, safe smoking assessments/reassessments, and updating comprehensive care plans for residents who smoke.

In addition, the administrator failed to ensure facility staff were assessing, monitoring, providing care related to lymphedema and wounds.

Findings were:

An onsite survey was conducted from 06/28/2016 through 06/30/2016. During the survey deficient practice was identified regarding the facility's failure to ensure a safe smoking environment for residents identified as needing supervision and/or adaptive equipment for smoking, including enforcement of the smoking policy.safe smoking assessments/reassessments, and updating comprehensive care plans for residents who smoke. The facility also failed to assess and provide MD ordered treatment and services to address a resident with lymphedema, cellulitis, and a wound; the facility also failed to follow the policy for wound care.

Interviews were conducted with the administrator throughout the survey process regarding the identification of immediate jeopardy with resultant substandard quality of care in the area listed above. The administrator stated that for resident's who were smokers, if they were

F 490:

accepted by the Surveyors.
2. Facility Policy on smoking, wound care and refusal of care will be reviewed. Smoking area will be reviewed for safety and adequacy. Recommendation will be reviewed by Policy Committee.
3. Re-education of the Facility Staff will be completed on the following:
a) MFA Smoking policy and procedure
a. Auditing of smoking and wound documentation.
b. MFA policy and procedures on refusal of treatment and medication.
4. The Vice President of Operation (VPO) will review the status of safe smoking environment in the facility and wound management with the Administrator to ensure their adherence to the MFA policies and procedures quarterly, for three quarters. Any deviations will be forwarded to the QA committee for resolution.

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	495121		C 06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYDALE HEALTH AND REHABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207

(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 OATE

F 490 Continued From page 117

F 490

deemed cognitive they were allowed to smoke unsupervised. He further stated there was no schedule, per the facility policy, for smokers requiring supervision. The administrator indicated through interviews with the survey team : that a resident identified as having seizures while smoking was aware of, and accepted, the risks. The administrator stated "If a cognitive resident has a seizure while smoking, is he likely to burn himself? Maybe, but he may just get a few ashes on himself; I don't know that other residents in the area if that were to happen would be affected....if so, they may get a few ashes on them as well."

The administrator also addressed the resident with lymphedema and a wound by stating "The daughter of the resident would not let the staff look at the wound; she insisted on doing the lymphedema wraps herself since she had been taught to do that, and was identified in writing from the wound clinic as 'skilled provider of lymphedema wrapping'." There was no documentation the daughter was competent in the care of the wound located under the lymphedema wrap. When asked if staff had observed the daughter performing the care to the resident, and in doing so, observe the wound, the administrator again stated the daughter had refused to let the staff observe or touch the resident's leg. The resident was listed on the face sheet of the medical record as her own responsible party (RP); the daughter was not listed as the RP nor was she the POA (power of attorney). The administrator stated he and the resident's physician were under the impression the resident was going to the wound clinic weekly. The administrator was asked if a physician order was needed for that, and he stated "Yes." There was not a physician order for the resident to go to

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F 490	Continued From page 118 the wound clinic weekly. No further information was provided prior to the exit conference.	F 490j		
F 501 SS=E	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on complaint investigation, observations, clinical record review, staff interview, family interview, and facility document review, the Medical Directors failed to exercise their responsibilities for the implementation of resident care policies and procedures, and failed to ensure the coordination of medical care for the facility's residents. The failure to provide a safe smoking environment for those residents who smoked lead to the identification of Immediate Jeopardy and Substandard Quality of Care at Federal tag F-323. The failure to assess, monitor, and ensure the provision of physician ordered treatment and services to a resident who was admitted with lymphedema, cellulitis and a wound, lead to the identification of Immediate Jeopardy and Substandard Quality of Care at Federal tag	F 501:	F501 Cross Reference to 12 VAC 5-371-230 (8)(1) and (2) 1. Correction completed for both IJs on 6/29/16 and 6/30/16 and were accepted by the Surveyors. 2. The Medical Directors to review the documentation of all active smokers and treatment administration for all current wounds, for appropriateness. 3. Medical Director will participate in a Review of: a. MFA Smoking policy and procedure b. MFA policy and procedures on refusal of treatment, medication, and care in general c. Alternative consideration to non-smoking facility 4. The Administrator in consultation with the DON will review with the Medical Directors the status of safe smoking environment in the facility and current	8/1/16

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F 501	Continued From page 119 F-309.	F 501	wound management to assessment their compliance with medical standards and that of the MFA policies and procedures on the two issues quarterly for three quarters. Any deviations will be forwarded to the QA committee for resolution.	

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CHERRYDALE HEALTH AND REHABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207

(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)	(XS) COMPLETION DATE
F 000	INITIAL COMMENTS	F OOOj		
	An unannounced Medicare/Medicaid standard survey was conducted 06/09/2015 through 06/11/2015. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 240 certified bed facility was 221 at the time of the survey. The survey sample consisted of 27 current Resident reviews (Resident #1 through Resident #27) and three closed record reviews (Resident #28 through Resident #30).			
F 155 SS=D	RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES CFR(s): 483.10(b)(4)	F155		
	The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with-the-reqtJirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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

06/25/2015

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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CHERRYDALE HEALTH AND REHABILITATION CENTER	710 LEE HIGHWAY ARLINGTON, VA 22207

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F 155	, Continued From page 1	F 155		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a Durable Do Not Resuscitate (DDNR) was accurate and complete for one of 30 residents in the survey sample, Resident #13.

Resident #13's DDNR was not completed for numbers 1 and 2.

The findings inciude:

Resident #13 was originally admitted to the facility on 8/20/12 and readmitted on 12/2/14 with, but not limited to, the following diagnoses: dental caries, chronic, pain, depression and anxiety. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/1/15 was a quarterly assessment. The resident was assessed as a 10, cognitively intact and able to make needs known.

On 6/9/15 at approximately 3:00 p.m., Resident #13's clinical record was reviewed to include the following DDNR: "I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest...I further certify [must check: 1 or 2)..." Upon review of the DDNR, neither 1 or 2 was checked.

On 6/9/15 at approximately 3:45 p.m., the unit

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F 155	Continued From page 2	F 155		
	manager, who was a licensed practical n.urse and will be identified as LPN # 1 was interviewed regarding the incomplete DDNR. LPN #1 reviewed the DDNR and stated, "It, section 1 or 2, is supposed to be signed and checked." When interviewed and asked how did the facility determine if the resident was capable of signing the DDNR if the form was incomplete; LPN# 1 stated, "The doctor fills out the form and the her doctor does not practice here anymore, she has another doctor and when he comes in I will get him to redo the form." On 6/10/15 at approximately 1:15 p.m., the administrative staff was made aware of the above findings. No further information was provided during the course of the survey regarding the incomplete D0NR for Resident #13.			
F 278 SS=D:	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g) - (j) The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 2781		

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F 278	Continued From page 3 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate and complete Minimum Data Set (MOS) for one of 30 residents in the survey sample, Resident #3. Section C. "Cognitive Patterns" of the MOS Assessment with an Assessment Reference Date (ARD) of 5/12/15, a quarterly assessment was not completed by the MOS Coordinator. The findings include: Resident #3 was originally admitted to the facility on 7/29/14 and readmitted on 4/10/15, with, but not limited to, the following diagnoses: meningioma of the frontal lobe, Parkinson's disease, bipolar disorder, deep vein thrombosis, dysphagia requiring a gastrostomy tube (G-tube). The most recent Minimum Data Set (MOS) with an Assessment Reference Date (ARD) of 5/12/15. was a quarterly assessment. Section C was	F 278		

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F 278	Continued From page 4 incomplete. On 6/10/15 at approximately 10:00 a.m., Resident #3's MOS assessment was reviewed in the clinical record. Upon review of the MOS, Section C. "Cognitive Patterns" was not completed by the MOS Coordinator. On 6/10/15 at approximately 11:20 a.m., the MOS Coordinator, who was a registered nurse and will be identified as RN #2 was interviewed regarding the incomplete MOS assessment. RN #2 reviewed the MOS with an ARD Of 5/12/15 and stated, "I missed it I could not go back to do the interview after the ARD date. I only have twenty four hours to the the interview. I could have gotten it (cognitive patterns information) from other areas, the doctor's notes and staff but I didn't." On 6/10/15 at approximately 1:15 p.m., the administrative staff was made aware of the above findings. No further information was provided during the course of the survey regarding the incomplete MOS assessment for Resident #3.	F 278		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d), 483.20(k)(1) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 2791		

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needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b){4).

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to develop a comprehensive care plan (CCP) for one of 30 residents in the survey sample, Resident #18.

Facility staff failed to develop a CCP regarding Resident #18's use of alcohol and his subsequent behaviors.

Findings included:

Resident #18 was originally admitted to the facility. on 01/23/2015 and readmitted on 02/05/2015 with: diagnoses including, but not limited to: Syncope, Dysphagia, Hypertension, Hypothyroidism, Depression, Malignant Neoplasm of Head/Face Status post Chemotherapy and Radiation, and Alcohol Abuse with Seizures.

The most recent MOS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/15/2015. Resident #18 was assessed as cognitively intact with a total

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F 279	Continued From page 6 cognitive score of 15 out of 15. During the clinical record review on 06/10/2015 at approximately 9:00 a.m., documentation in the clinical progress notes described episodes of Resident #18 being intoxicated on 04/18/15, 04/29/15, 05/28/15 and 06/01/15. The resident was described as having "gait unsteady, speech slurred, lacks coherence...resident oriented to self only, in and out of sleepiness ...responds to commands. Alcohol smelling substance noted in styrofoam cup sitting on bedside table...MD (physician) called and updated...Resident offered prn (as needed) oxygen for SOB (shortness of breath) but refused stating (sic) 'I will be ok. Soon I'm gonna pee the alcohol out of my system.' Resident is self RP (responsible party)." On 06/01/2015 at 10:24 a.m., Resident #18 was observed by the Social Worker (SW) and the following was documented in his clinical record. "Patient was observed in the smoking section yelling and cursing at other residents. Patient was using hurtful language...According to other residents he threatened physical harm to them. Writer was able to remove patient to another location where he can calm down. Patient appeared to be intoxicated evident by his slurred speech, drooling, unsteady gate, and caring the odor of alcohol...Patient became belligerent evident by him continuing to yell and scream and writer and other staff. (Name) County Police were called were intervened. Police officer spoke with patient who had a tall white Styrofoam cup in which he was drinking from. Police removed cup from patient where alcohol contents were evident...after further conversation with the officers the patient increasingly became belligerent. He was arrested and discharged into ,	F 279		

STATEMENT *OF* DEFICIENCIES ANO PLAN *OF* CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
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CHERRYDALE HEALTH AND REHABILITATION CENTER	**3710** LEE **HIGHWAY** **ARLINGTON, VA 22207**

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the custody of the (Name) County Police Department." (sic) Further documentation in clinical record revealed Resident #18 was released to himself later in the evening and returned to the facility.

On 06/02/2015 at 12:08 p.m., the following documentation was recorded by the Social Worker. "Writer educated patient on risks of drinking while taking certain medications. Patient was *offered* substance abuse counseling and he declined...Writer notified patient county SW (social worker)...that patient is back in the facility..."

Resident #18 was seen by Geriatric Psychiatry on 03/26/15, 04/16/15 and had been referred for another evaluation on 05/05/15. Geriatric Psychiatry physician was in the facility during the survey and planned to evaluate this resident on 06/11/15.

The only references made in the CCP regarding alcohol stated the following, "Focus - Care Needs: Related to: - Delirium with ETOH (alcohol) ABUSE, ...Alcohol withdrawal syndrome with DT's (delirium tremors), Alcohol withdrawal Seizure, ...Alcohol abuse continuous...Created on: 04/17/2015 Goal - Resident's basic care needs will be maintained through next review. Interventions - Administer medication and/or treatments as ordered; Monitor lab as ordered; Monitor vital signs; Notify MD/RP of significant changes in condition. Focus - The resident has occasional shortness of breath (SOB) r/t (related to) ETOH Created on: 05/26/2015 Goal - The resident will maintain normal breathing pattern... through the review date. Interventions - : Monitor/document changes in orientation,

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F 279	Continued From page 8 increased restlessness, anxiety, and air hunger; Monitor/documenVReport breathing abnormalities to MD; Position resident with proper body alignment for optimal breathing pattern." (sic) The Administrator and **DON** (director of nursing) were interviewed on 06/11/2015 at approximately 8:00 a.m. regarding the CCP for Resident #18. The Administrator stated, "He is alert and oriented, has his own money and is his own RP. We cannot stop him from leaving the building." The DON stated, "We cannot watch him when he is *off* of the grounds. We can't send someone to the (Name) store to make sure he isn't buying alcohol. We notify the physician when he comes back drunk." This surveyor asked if rules had been established with the resident regarding his drinking and drunkenness. The Administrator stated, "I guess we could do that." **The facility SW was interviewed at approximately** 8:45 a.m. regarding this resident. The SW stated, "We are working with the county SW (Name). He has been in every program in the county and has been kicked out. Resident #18 (Name) states he wants to be discharged. He is going to drink and likes living on the street. He is tentatively approved for an ALF (assisted living facility in (Location). We are waiting on authorization from (Name) county. (Name) Resident #18, County SW and myself met on Monday. We went over guidelines with the resident and he agreed. We did not document the guidelines. The meeting lasted about one and one half hours and we focused on discharge planning because that is his main concern right now. Since the incident he has said he doesn't want to return to jail. He hasn't drank since then."	F 279		

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F 279:

The Administrator and DON were informed of the above information during a meeting with the survey team on 06/11/2015 at approximately 10:00 a.m. No further information was received by the survey team prior to the exit conference on 0611112015.

F 280 RIGHT TO PARTICIPATE PLANNING

SS:D g: tJ:j (3), 483.10(k)(2)

F 280

, 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.

: 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 staff interview and clinical record review, the facility staff failed to review and revise **the CCP (Comprehensive Care Plan) for one of** 30 residents in the survey sample, Resident# 11.

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F 280	Continued From page 10	F 2801		

The facility staff failed to review and revise Resident# 11's CCP regarding smoking independently.

Findings include:

Resident# 11 was admitted to the facility on 12/11/14, with the most current readmission on 04/24/15. Diagnoses for Resident# 11 included, but were not limited to: TBI (traumatic brain injury), COPD (chronic obstructive pulmonary disease), unspecified psychosis with behavior issues and aggression.

The most current full MOS (minimum data set) with CAAS (care area assessment summary) was the admission assessment dated 12/18/14. This MDS assessed the resident with a cognitive score of "4", indicating the resident had severe impairment in daily decision making skills. This MDS also triggered the resident for behaviors in the CAAS section.

During clinical record review on 06/10/15 at approximately 11:00 a.m., Resident# 11 was observed in the dining room with a staff member very close by.

Resident # 11's clinical record was reviewed and documented that due to behavior issues, Resident # 11 was receiving 1:1 supervision from staff. The 1:1 intervention was initiated on 06/04/15.

Resident# 11's CCP was then reviewed and documented: "...redirect and/or remove...if behavior persist...may provide 1:1 if

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYDALE HEALTH AND REHABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207

(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)	(XS) COMPLETION DATE

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indicated...the resident is a smoker...The resident can smoke unsupervised..."

On 06/11/15 at 8:15 a.m., the Unit Manager-also known as LPN (Licensed Practical Nurse)# 2 was interviewed regarding the above information. The LPN was asked if the resident still went to smoke unsupervised. LPN # 2 voiced no and went on to say, 'he can but doesn't he is 1:1.' The LPN was then ask, since the resident is a 1:1 (and had been since 06/04/15) should the smoking information on the CCP have been updated to reflect that he was no longer independent in smoking. The LPN voiced, yes.

On 06/11/15 at approximately 9:40 a.m., the administrator, the DON (director of nursing) and the nurse consultant were made aware of the above information in a meeting with the survey am.

No further information or documentation was presented prior to the exit conference on 06/11/15 at11:30a.m.

F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS
SS=D CFR(s): 483.20(k)(3)(i)

F 281

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to follow professional standards of nursing practice for one of 30 residents in the survey sample, Resident #18.

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	495121		**06/11/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, *CITY, STATE,* ZIP CODE
CHERRYDALE HEALTH AND REHABILITATION CENTER	**3710 LEE HIGHWAY** **ARLINGTON, VA 22207**

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Facility staff failed to obtain a physician order prior to withholding medications for Resident #18 on 04/29/2015 and 05/28/2015.

Findings included:

Resident #18 was originally admitted to the facility on 01/23/2015 and readmitted on 02/05/2015 with, diagnoses including, but not limited to: Syncope, Dysphagia, Hypertension, Hypothyroidism, Depression, Malignant Neoplasm of Head/Face status post Chemotherapy and Radiation, and Alcohol Abuse with Seizures.

The most recent MOS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/15/2015. Resident #18 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

During the clinical record review on 06/10/2015 at approximately 9:00 a.m., a physician order dated 04/18/15 was noted that stated, "Hold all meds (medications) and monitor resident. Resume meds when resident is alert and normal." An *order* dated 04/19/15 stated, "Resume all medication."

Review of Resident #18's MAR's (medication administration records) revealed meds had not been given on 04/29/15 and 05/28/15. No physician orders could be located in the clinical record to hold these medications. According to Potter and Perry's, Basic Nursing Essential for Practice, 6th edition, 2007, pages 56-59, documents the following information: "The best way to avoid being liable for negligence is to follow standards of care, to give competent health

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CHERRYDALE HEALTH ANO REHABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207

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care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. (1)." Potter and Perry's Fundamentals of Nursing 7th edition 2009, page 336 documents the following information:

"Physician's Orders. The physician is responsible for directing medical treatment. Nurse's follow physician's orders unless they believe the orders are in error or harm clients. Therefore you need to assess all orders, and if you find one to be erroneous or harmful, further clarification from the physician is necessary... (2)."

The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 06/10/15 at approximately 1:15 p.m. The DON stated, "We will look for orders and get back with you."

During a meeting with the Administrator and DON on 06/11/2015 at approximately 8:00 a.m., the DON stated, "There are no other orders to hold medications. It was implied in the order written on 04/18/15." The Administrator showed this surveyor in a clinical progress note, dated 04/29/2015 at 14:42 (2:42 p.m.), the following documentation, "...MD (physician) called and updated about incident. MD gave order to hold all meds until resident mental status returns to baseline..." Again this surveyor asked if the order had been written and the Administrator stated, "No." No documentation was located in the record regarding meds being held on 05/28/2015. A copy of the facility policy for medication administration was requested by this surveyor.

The facility policy for "Medication Administration" effective "02/01/15" stated, "...Procedure: 1. Nursing staff members are to reference the

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F 281	Continued From page 14 established contracted provider's Pharmacy Services and Procedures Manual regarding medication orders, delivery, monitoring and other related processes for promoting efficiency and consistency in medication administration and standards of best practice..." No further information was received by the survey team prior to the exit conference on 06/11/2015. (1) Potter Patricia A. and Perry Anne Griffin. Fundamentals of Nursing. 6th Edition. St. Louis, Missouri: Mosby Elsevier, Inc, 2007. (2) Potter Patricia A. and Perry Anne Griffin. Fundamentals of Nursing. 7th Edition. St. Louis, Missouri: Mosby Elsevier, Inc, 2009.	F 2811		
F 469 SS=F	MAINTAINS EFFECTIVE PEST CONTROL PROGRAM CFR(s): 483.70(h}(4} The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, group interview, family interview, staff interview, facility document review and complaint investigation, the facility staff failed to maintain an effective pest control program to ensure the facility was free of mice. Residents, staff members and a family member reported and/or documented mice were seen in resident rooms, activity areas, dining rooms and in resident use areas in the facility on	F 469		

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F 469	Continued From page 15 an ongoing basis. The findings include: During the initial tour of the facility on 6/9/15 at 1:45 p.m. black and/or white pest control bait boxes for mice were observed in the floor of multiple residents' rooms. On 6/10/15 at 10:15 a.m. Resident#15 was interviewed about quality of life in the facility. Resident #15 stated she had not seen a mouse in about a month but prior to that she saw mice "all the time" on the 4th floor. On 6/10/15 at 10:45 a.m. Resident #8 was interviewed about quality of life in the facility. Resident #8 stated there were ongoing issues with mice in the facility. Resident #8 stated there were black boxes in all the rooms to help control mice. Resident #8 stated there had been a mouse in the vending machine on the third floor and mice throughout the facility. On 6/10/15 at 4:00 p.m. an interview was conducted with a group of 16 cognitively intact residents. Twelve out of the 16 residents stated theydhadt actuadlly s enhmiceb in the facility. The res, en s state mice ad een seen throughout the facility "for about a year." Residents stated mice had been seen in resident rooms, in dining rooms and the activity room in the facility. Resident stated the pest control company put out sticky "glue" traps and had recently changed to a black chemical trap to help kill the mice. One resident stated, "I saw a mouse run across the floor in the activity room." Several residents stated a mouse was found/removed from the vending machine on the third floor. When asked if the mice problem had been resolved, the residents stated, "No." Residents stated they still	F 469		

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i heard mice running in the ceiling at night.

Resident council meeting minutes dated 4/10/15 , stated, "Mice in 3rd + 4th fl. (floor) ceilings @ PM. More mice noted even in 3rd fl. (floor) dining room. Hole is by the 1st table on left, and near , piano. Also, pipe that goes to floor fr. (from) ' basement should have ring around it so mice can't use it as highway to other floors they said." , The resident council meeting minutes dated i 5/14/15 documented, "Mice decreased per : residents..."

On 6/11/15 at 8:00 a.m. the facility's director of housekeeping responsible for pest control was i interviewed about mice in the facility. The housekeeping director stated there was an , increase in mice activity reported in February ' 2015 and their contracted pest control vendor made extra visits to the facility. The housekeeping director stated prior to February 2015 reports of mice had been "sporadic." The housekeeping director stated in February 2015 [she received reports of mice in resident rooms i and other areas of the facility. The housekeeping director stated the pest vendor initially used glue . type traps for the mice but they were not very . effective so they switched to a chemical bait type trap. The housekeeping director stated the . chemical bait traps had been more effective than the glue traps. The housekeeping director stated the highest mouse activity was in rooms where , residents hoarded food items. The housekeeping ! director presented copies of the facility's pest monitoring logs from December 2014 through 6/9/15.

The facility's pest monitoring logs documented i the following reports of mice in the facility.

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: December 2014 - 8 reports of actual mice and/or droppings in rehab office, dining office, dining area, RD (registered dietitian) office, resident rooms 413, 325

January 2015 - 14 reports of mice and/or droppings in admission office, 2nd floor activity room, resident rooms 209,210,211,220,304, 312,313,415,429,435,523

February 2015 - 8 reports of mice and/or droppings in resident rooms 304, 312, 316, 325, 329,331,504, 513

March 2015 - 24 reports of mice and/or droppings in kitchen, RD office, dish room, dry storage, 5th floor shower room, resident rooms 203, 205, 210, : 211,504,506,515,517,521,525,526

April 2015 - 17 reports of mice and/or droppings in kitchen, HVAC room, across from , administrator's office, ceiling, coming out of open outlet, resident rooms 201,202,205,212,413, 414,415,504,520,524,525

May 2015 - 3 reports of mice and/or droppings in pantry, resident rooms 400, 531

June through 6/9/15 - 1 report of mouse in room 305

On 6/11/15 at 10:30 a.m. Resident #12's family member was interviewed about quality of life in the facility. Resident #12's family member stated the facility had an "ongoing mouse issue." Resident #12's family member stated she visited : the facility approximately two weeks ago and saw a mouse in her mother's room. The family

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F 469	Continued From page 18 member stated she was very concerned that mice were in resident rooms and in areas in the facility routinely used by residents. These findings were reviewed with the administrator, director of nursing and nursing consultant during a review meeting on 6/11/15 at 10:00 a.m. This was a complaint deficiency. 2. Resident# 16 in the survey sample, a 73 year-old female, was admitted to the facility on 12/8/11, and most recently readmitted on 3/12/14 with diagnoses that included diabetes mellitus, generalized muscle weakness, chronic obstructive pulmonary disease, anxiety state, depressive disorder, joint (shoulder) pain, hypertension, gastroesophageal reflux disease, hyperlipidemia, seizure disorder, obstructive sleep apnea, insomnia, and shortness of breath. According to the most recent Minimum Data Set, a Quarterly review with an Assessment Reference Date of 5/26/15, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. At 3:30 p.m. on 6/9/15, the resident was interviewed in her room. Asked about her room, Resident # 16 said, "My room is fine. I have no more mice." When asked to elaborate, the resident said, "I had two mice about a month ago. They put down a sheet of sticky paper, but he mice just walked around it. Then they put down some pellets. When the mice smelled them, one died but the other didn't. One of the CNA's (Certified Nursing Assistant) caught that one."	F 469		

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At 8:30 a.m. on 6/11/15, the two female residents in a room on the fourth floor were interviewed about a report of mice in their room. Both residents said there were mice in their room as recently as two weeks ago. "They get in my dresser drawers," one of the females said. "I don't know how they can do that." The other female resident then said, "I'm afraid one of them will get in bed with me. I'll probably have a heart attack." During the interview, a black, triangular shaped mouse trap was observed on the floor next to the HVAC unit located under the window in the room.

COMPLAINT DEFICIENCY

F 502 SS=E	ADMINISTRATION CFR(s): 483.75(j)(1)	F 5021		

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to obtain physician ordered lab tests for one of 30 residents in the survey sample, Resident #18.

Facility staff failed to obtain TSH (thyroid stimulating hormone) tests as directed in a physician order dated 03/25/15.

Findings included:

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F 502	Continued From page 20 Resident #18 was originally admitted to the facility ion 01/23/2015 and readmitted on 02/05/2015 with diagnoses including, but not limited to: Syncope, Dysphagia, Hypertension, Hypothyroidism, Depression, Malignant Neoplasm of Head/Face status post Chemotherapy and Radiation, and Alcohol Abuse with Seizures. The most recent MOS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/15/2015. Resident #18 was assessed as cognitively intact with a total cognitive score of 15 out of 15. During the clinical record review on 06/10/2015 at approximately 9:00 a.m., a physician order dated 03/25/15 was noted that stated, "TSH every night shift until 04/08/2015." Review of lab results in the clinical record revealed a TSH level dated 03/25/15. No further TSH level results could be iocated in the clinical record. The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 06/10/2015 at approximately 1:10 p.m. The DON stated, "We will clarify this and see if the labs were obtained." On 06/11/2015 at approximately 9:25 a.m., the Administrator stated, "The TSH levels were not obtained daily and no clarification order was written." No further information was received by the survey team prior to the exit conference on 06/11/2015.	F 502		

DEPARTMENT OF-HEALTH AND HUM.ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2016
FORM APPROVED
0MB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING [redacted] B. WING	(X3) DATE SURVEY COMPLETED
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	F 000 INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 1/12/16 through 1 /13/16. Two complaints were investigated during the survey. The facility was in substantial compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 240 certified bed facility was 227 at the time of the survey. The survey sample consisted of three current resident reviews (Residents 1 through 3) and one closed record review (Resident 4).	F 000		

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

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.