STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515103	A. BUILDING _____ B. WING _____	03/30/2017

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GLENVILLE HEALTH & REHAB	111 FAIRGROUND ROAD GLENVILLE, WV 26351

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F 000	INITIAL COMMENTS . Unannounced annual Quality Indicator and State Licensure Surveys were conducted at Glenville Center from 03/27/17 through 03/30/17. The deficiencies contained in this report are based on observations, review of residents' clinical records, resident interviews, family interviews, and staff interviews, and review of other facility documentation as indicated. The facility's census on the first day of the survey was 61 residents. The survey sample consisted of 22 Stage 2 residents. .	F 000	In addition to an acceptable plan of correction, submit credible evidence for all deficiency citations contained in this CMS-2567. F000 "The Glenville Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed because it is required by federal and state law."	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i)Identification and demographic information (ii)Customary routine. (iii)Cognitive patterns. (iv)Communication. (v)Vision. (vi)Mood and behavior patterns. (vii)Psychological well-being. (viii)Physical functioning and structural problems. (ix)Continence. (x)Disease diagnosis and health conditions.	F 272	F272 1. Section M0300 GI, G2 of the Minimum Data Set for resident #62 was corrected by the Clinical Reimbursement Coordinator on 4/12/17. 2. All residents of the facility have the potential to be affected. An audit of Section M0300 GI, G2 of the most recent Minimum Data Set submitted for all residents in facility was completed by Clinical Reimbursement Coordinator on 4/19/17, with corrective action upon discovery. 3. Re-education was completed with Clinical Reimbursement Coordinator by the Clinical Reimbursement Manager on accurately completing Section M0300 GI,	04/27/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/19/2017

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	(xi)Dental and nutritional status. (xii)Skin Conditions. (xiii)Activity pursuit. (xiv)Medications. (xv)Special treatments and procedures. (xvi)Discharge planning. (xvii)Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii)Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. . Based on record review and staff interview, the facility failed to ensure the accuracy of the Admission Minimum Data Set (MDS) for one (1) of two (2) residents reviewed for pressure ulcers. The comprehensive assessment was incorrectly coded indicating Resident #62 was admitted with two (2) suspected deep tissue injuries (SDTI). Resident identifier: #62. Facility census: 61. Findings include: a) Resident #62 Review of the medical record, on 03/29/17 at		G2 of the Minimum Data Set on 4/12/17 with a posttest completed to validate understanding. An audit will be completed by Center Nurse Executive/designee to check accuracy of Section M0300 GI, G2 of the Minimum Data Set prior to submission weekly x 4 weeks and then as determined by the Quality Improvement Committee. 4. Center Nurse Executive/designee will provide a summary of findings and the action taken monthly to the Quality Improvement Committee for any additional follow-up and/or inservicing until issue is resolved and randomly thereafter.	

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12:17 p.m., revealed Resident #62 was admitted to the facility from an acute care center on 02/27/17. The initial nursing admission assessment dated 02/28/17, states the resident had a healed suspected deep tissue injury (SDTI) to the right inner heal and left heal.

The pre-admission screening form dated 02/27/17 stated the resident did not have a pressure ulcer.

The physician history and physical dated 03/01/17, stated under the physical exam the resident did not have any rashes or ulcers under the skin inspection section.

The Nursing Assessment for the expanded electronic medical record completed by the Assistant Director of Nursing on 03/06/17, notes there are no skin impairments present.

The admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/06/17, indicates the resident was admitted with unhealed pressure ulcers under section M0210. Section G of M0300 incorrectly states Resident #62 was admitted with two (2) suspected deep tissue injuries in evolution.

The wound care/Licensed Practical Nurse (LPN) #19 was interviewed on 03/29/17 at 2:20 p.m. She confirmed Resident #62 was admitted with healed suspected deep tissue injuries to the left heel and right inner foot. The admitting nurse had initiated treatment as a preventative measure.

At 2:30 p.m. on 03/29/17, MDS Coordinator #65 stated she coded the admission MDS based on information she gathered from the Skin Integrity

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	Report form and the fact that treatment had been initiated. The MDS coordinator acknowledged she had not reviewed the physician's history and physical, asked the nursing staff, or examined the resident. The Assistant Director of Nursing (ADON) stated the admission MDS with an ARD of 03/06/17, was coded incorrectly during an interview on 03/29/17 at 3:33 p.m. Resident #62 was not admitted with two (2) SDTI. .			
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (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. (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	F 278	F278 1. Section M0300 Gl, G2 and section G part H of the Minimum Data Set for resident #62 was corrected on 4/12/17 and section 18000B for resident #74 on 3/29/17 by the Clinical Reimbursement Coordinator. 2. All residents of the facility have the potential to be affected. An audit of Section M0300 Gl, G2, section G part H, and section 18000B including skin conditions and activities of daily living of the most recent Minimum Data Set submitted for all residents in facility was completed by Clinical Reimbursement Coordinator on 4/19/17, with corrective action upon discovery. 3. Re-education was completed with Clinical Reimbursement Coordinator by the Clinical Reimbursement Manager on accurately completing Section M0300 G1	04/27/17

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	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. . Based on record review, review of the Resident Assessment Instrument (RAI) Version 3.0 Manual and staff interview, the facility failed to ensure the assessment was accurate regarding pressure ulcers. In addition, Resident #62's quarterly assessment was inaccurately coded under section G indicating a decline in eating. Section 1800B of Resident #74's quarterly assessment contained an incorrect additional diagnosis of a Stage 2 pressure ulcer. The minimum data set (MDS) coordinator failed to use direct observation and communication with the staff during the resident assessment process. This was found for two (2) of two (2) residents reviewed for pressure ulcers. Resident identifier: #62 and #74. Facility census: 61. Findings include: a) Resident #62 1. Pressure ulcers Review of the medical record, on 03/29/17 at 12:17 p.m., revealed Resident #62 was admitted to the facility from an acute care center on 02/27/17. The initial nursing admission assessment dated 02/28/17, states the resident had a healed suspected deep tissue injury		G2, section G part H, and section 18000B of the Minimum Data Set including coding of skin conditions, and use of meal percentage review and staff interviews during coding of resident activities of daily living on 4/12/17 with a posttest completed to validate understanding. An audit will be completed by Center Nurse Executive /designee to check accuracy of Section M0300 G1 and G2, section G part H, and section 18000B including skin conditions and activities of daily living of the Minimum Data Set prior to submission weekly x 4 weeks and then as determined by the Quality Improvement Committee. 4. Center Nurse Executive/designee will provide a summary of findings and the action taken monthly to the Quality Improvement Committee for any additional follow-up and/or inservicing until issue is resolved and randomly thereafter.	

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(SDTI) to the right inner heal and left heal.

The pre-admission screening form dated 02/27/17 stated the resident did not have a pressure ulcer.

The physician history and physical dated 03/01/17, stated under the physical exam the resident did not have any rashes or ulcers under the skin inspection section.

The Nursing Assessment for the expanded electronic medical record completed by the Assistant Director of Nursing on 03/06/17, notes there are no skin impairments present.

The admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/06/17, indicates the resident was admitted with unhealed pressure ulcers under section M0210. Section G of M0300 incorrectly states Resident #62 was admitted with two (2) suspected deep tissue injuries in evolution.

The wound care/Licensed Practical Nurse (LPN) #19 was interviewed on 03/29/17 at 2:20 p.m. She confirmed Resident #62 was admitted with healed suspected deep tissue injuries to the left heel and right inner foot. The admitting nurse had initiated treatment as a preventative measure.

At 2:30 p.m. on 03/29/17, MDS Coordinator #65 stated she coded the admission MDS based on information she gathered from the Skin Integrity Report form and the fact that treatment had been initiated. The MDS coordinator acknowledged she had not reviewed the physician's history and physical, asked the nursing staff, or examined the resident.

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The Assistant Director of Nursing (ADON) stated the admission MDS with an ARD of 03/06/17, was coded incorrectly during an interview on 03/29/17 at 3:33 p.m. Resident #62 was not admitted with two (2) SDTI.

2. Decline in eating

Review of the medical record on 03/29/17 at 12:17 p.m., revealed Resident #62's quarterly MDS with an ARD of 03/13/17, indicates she declined in her ability to eat independently since admission. The eating section of section G states she now requires supervision with meals. The activity of daily living (ADL) sheets note Resident #62 was independent with eating 11 of 14 opportunities. No observations were documented for the day shift on 03/07/17, 03/08/17 and evening shift on 03/13/17. The meal consumption section of the ADL form indicates the resident consumed all or part of all three meals on 03/07/17 and 03/08/17; and she consumed 50-100% of two of the three meals on 03/13/17.

Nurse Aide (NA) #52 confirmed Resident #62 was independent with meals after set up during an interview on 03/29/17 at 2:47 p.m.

The occupational therapist #38 confirmed Resident #62 did not require assistance with meals during an interview on 03/29/17 at 3:30 p.m.

The MDS Coordinator #65 reviewed the ADL sheets during an interview at 3:00 p.m. on 03/29/17. She reported she marked the MDS assessment under section G part H as supervision with eating because the ADL form

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was blank in three (3) of fourteen (14) sections for eating in the seven (7) day look back period. Upon further questioning, the MDS nurse acknowledged she had not reviewed the meal percentage intake section for this seven day period and had not questioned the staff regarding a possible decline in Resident #62's independence with eating.

The ADON reviewed the ADL sheets during an interview, on 03/29/17 at 3:33 p.m., and confirmed the MDS nurse should have conducted a further investigation related to Resident #62's eating abilities.

b) Resident #74

Review of the medical record, on 03/29/17 at 10:41 a.m., revealed Resident #74 was admitted to the facility from an acute care center for treatment of moisture associated skin damage (MASD) and the inability to care for himself. The acute care discharge summary dated 10/01/16, notes the resident has a large abdominal pannus (or abdominal aprom, the layer of fat covered by skin on the abdomin of obese or formerly obese individuals) with erythema (redness of the skin) and excoriation (abrasion of the skin) and no pressure ulcers.

The Nursing Admission Assessment dated 10/01/16 identifies MASD in the left lower quadrant of the abdominal fold, the left and right groin, posterior scrotum, and an excoriation to the left posterior thigh.
The Skin Integrity Report form dated 10/01/17 identifies the admission wounds as MASD.
Section I8000B of the quarterly MDS with an ARD of 01/10/17, incorrectly lists the additional diagnosis: "Pressure Ulcer of Other Site, Stage

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	2." The wound care nurse/Licensed Practical Nurse #19 confirmed Resident #74 had never had a pressure ulcer during an interview on 03/29/17 at 10:51 a.m. The MDS coordinator acknowledged the quarterly MDS with and ARD of 01/10/17 was incorrect under section I8000B during an interview on 03/29/17 at 11:44 a.m. This information was obtained form the Health Information Management Director (HIMD) who obtains her information from review of portions of the medical record. The MDS nurse acknowledged she did not assess the resident or interview the staff when completing this assessment. .			
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 (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	F 279	F279 1. Care plan for resident #23 updated to include use of anti-platelet medication and side effects including bleeding and/or bruising precautions related to the medication Plavix by the Clinical Reimbursement Coordinator on 4/4/17. Resident #23 has not experienced any negative outcome. Resident #24 no longer resides in facility. 2. All residents have the potential to be affected. Audit of care plans completed for current residents with anti-platelet medications for presence of medication and side effects including bleeding	04/27/17

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	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 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		and/or bruising precautions by Clinical Reimbursement Coordinator on 3/30/17, with corrective action upon discovery. Audit of care plans completed for residents re-admitted within the last 3 months for accuracy of urinary continence by the Clinical Reimbursement Coordinator on 4/12/17, with corrective action upon discovery. 3. Re-education will be provided to all licensed nurses by Nurse Practice Educator/designee to develop a comprehensive care plan based on a resident's current health condition/status that included measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs including concerning urinary continence following re-admission and identifying use of anti-platelet medication and side effects including bleeding and/or bruising precautions on or before 4/27/17 with a posttest completed to validate understanding. Staff not available during this time frame will be provided re-education post-test upon return to work by the Nurse Practice Educator/designee to include new hires during orientation. Audit of care plans including changes in urinary continence and anti-platelet medications side effects including bleeding and/or bruising precautions will be completed by Clinical Reimbursement Coordinator/designee daily x 2 weeks including weekends, 3 x per week x 2 weeks and then as determined by the Quality Improvement Committee. Results	

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	section. . b) Resident #24 Review of the medical record, on 03/28/17 at 1:01 p.m., revealed Resident #24 developed a decline in urinary incontinence after hospitalization. The Activity of Daily Living (ADL) forms indicate the resident became totally incontinent of urine as of 12/03/16. The Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 01/16/17 identifies the resident as always being incontinent of urine. The care plan with a review date of 01/26/17, is silent in regards to Resident #24's urinary incontinence. The MDS Coordinator #65 acknowledged Resident #24 had a decline in urinary continence after repeat hospitalizations during an interview on 03/28/17 at 2:30 p.m. The MDS Coordinator reviewed the care plan and confirmed it lacked any information related to urinary incontinence. . . Based on record review and staff interview, the facility failed to develop a comprehensive care plan based on a resident's current health condition/status that included measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs. Two (2) of twenty-two (22) Stage 2 sample residents whose care plan was reviewed during the Quality Indicator Survey (QIS) were affected. Resident #23's care plan did not address side effects or precautions for anti-platelet therapy. Resident #24's care plan did not address urinary incontinence. Resident identifiers: #23 and #24.		of audits will be reviewed randomly with the Center Executive Director/designee. 4. Clinical Reimbursement Coordinator/designee will provide a summary of findings and the action taken monthly to the Quality Improvement Committee for any additional follow-up and/or inservicing until issue is resolved and randomly thereafter.	

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Facility census: 61.

Findings include:

a) Resident #23

Review of the medical record, on 03/30/17 at 8:27 a.m., revealed Resident #23 was admitted on 10/08/14. His diagnosis include cerebrovascular accident with left hemiparesis and arteriosclerotic heart disease. He was prescribed the anti-platelet medication Plavix for atherosclerotic heart disease.

The care plan revealed a focus initiated on 10/09/14 for:
--Resident is at risk for cardiovascular symptoms or complications related to a diagnosis of coronary artery disease and hypertension.

Interventions:
--Administer meds as ordered and assess for effectiveness and side effects and report abnormalities.

The care plan was silent for any side effects and/or bleeding and/or bruising precautions related to the medication Plavix.

On 03/30/17 at 9:05 a.m., the Clinical Case Coordinator/minimum data set (MDS) #65 stated, "We just put all medications to take as ordered, but I will look at the care plan when the computers come back up."

At 9:18 a.m. on 03/30/17 the Clinical Case Coordinator/MDS #65 reported, "I looked at the care plan and it does not contain anything related to bleeding precautions or bruising for the Plavix. I agree it should have those interventions and will

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	correct now."			
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. . Based on record review and staff interview, the facility failed to implement care plan interventions for a resident with a dialysis Arteriovenous (AV) shunt. Resident #59 did not have her AV shunt monitored for bruit and thrill every shift and as needed (prn) as directed by her care plan. This practice affected one (1) of one (1) dialysis resident in the facility. Resident identifier: #59. Facility census: 61. Findings include: a) Resident #59 Review of the medical record, on 03/28/17 at 1:44 p.m., revealed Resident #59 was initially admitted to the facility on 03/04/17 and readmitted after a hospitalization on 03/21/17. Her diagnosis includes, end stage renal disease with dialysis. She has an AV shunt for dialysis access. On 03/21/17 a Physician order stated (typed as written) "Monitor dialysis graft every shift for bruit and thrill." Bruit is the sound of blood flowing	F 282	F282 1. The Treatment Administration Record for resident #59 was updated to include monitoring for Arteriovenous (AV) shunt bruit and thrill every shift as per physician order and care plan on 3/28/17 by the Assistant Director of Nursing. 2. All residents of the facility have the potential to be affected. There are no additional residents in facility currently requiring dialysis services. 3. Re-education will be provided to all licensed nurses by Nurse Practice Educator / designee concerning need to implement care plan interventions for a resident with a dialysis Arteriovenous (AV) shunt including monitoring of dialysis arteriovenous (AV) shunts on or before 4/27/17 with a posttest completed to validate understanding. Staff not available during this time period will be provided re-education including post-test upon return to work by the Nurse Practice Educator/designee to include new hires during orientation. If the center would have a resident begin dialysis services, an audit of Treatment Administration Records will be completed to ensure that the physician order and care plan are followed by the Center Nurse Executive/designee daily x 2	04/27/17

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	through the AV shunt. Thrill is the vibration of blood going through the arm. The care plan contained an intervention initiated on 03/06/17 (typed as written): --"Monitor dialysis access for +bruit/+thrill q (every) shift and prn." Inquired about the location of dialysis AV shunt assessment documentation on 03/28/17 at 2:46 p.m. from Licensed Practical Nurse (LPN) #28 and LPN/wound nurse #19 due to being unable to locate documentation in the medical record. LPN #28 commented, "It should be in the TAR (treatment administration record) or the MAR (medication administration record), I will look." LPN/wound nurse #19 stated, "No it should be in her TAR, I will look." After searching the TAR, LPN/wound nurse #19 stated, "There is nothing in the TAR since her readmission to show that the AV shunt was monitored or assessed, there is not even a page in here for it to be monitored or assessed. I can't believe we missed it." Upon further inquiry LPN/wound nurse #19 stated, "As nurses, we all know if it is not documented then it wasn't done. No the physician order nor the care plan were followed for monitoring or assessment of the shunt." .		weeks, then 3 x per week x 2 weeks, then as determined by the Quality Improvement Committee. Results of audits will be reviewed randomly with the Center Executive Director/designee. 4. Center Nurse Executive/designee will provide a summary of findings and the action taken monthly to the Quality Improvement Committee for any additional follow-up and/or inservicing until issue is resolved and randomly thereafter.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care	F 309	F309 1. The Treatment Administration Record for resident #59 was updated to include monitoring for Arteriovenous (AV) shunt bruit and thrill every shift as per	04/27/17

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	and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and staff interview, the facility failed to monitor and assess an arteriovenous (AV) fistula as ordered by the Physician. This practice affected one (1) of one (1) dialysis resident in the facility. Resident identifier: #59. Facility census: 61. Findings include: a) Resident #59		physician order and care plan on 3/28/17 by the Assistant Director of Nursing. 2. All residents of the facility have the potential to be affected. There are no additional residents in facility currently requiring dialysis services. 3. Re-education will be provided to all licensed nurses by Nurse Practice Educator/designee concerning the facility must ensure that residents who require dialysis receive services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences such as monitoring dialysis Arteriovenous (AV) shunts on or before 4/27/17 with a posttest completed to validate understanding. Staff not available during this time period will be provided re-education including post-test upon return to work by the Nurse Practice Educator/designee to include new hires during orientation. If the center would have a resident begin dialysis services, an audit of Treatment Administration Records will be completed to ensure that the physician order and care plan are followed by the Center Nurse Executive/designee daily x 2 weeks including weekends, then 3 x per week x 2 weeks, then as determined by the Quality Improvement Committee. Results of audits will be reviewed randomly with the Center Executive Director/designee.	

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	Review of the medical record, on 03/28/17 at 1:44 p.m., revealed Resident #59 was initially admitted to the facility on 03/04/17 and readmitted after a hospitalization on 03/21/17. Her diagnosis includes, end stage renal disease with dialysis. She has an AV shunt for dialysis access. On 03/21/17 a Physician order stated (typed as written) "Monitor dialysis graft every shift for bruit and thrill." Bruit is the sound of blood flowing through the AV shunt. Thrill is the vibration of blood going through the arm. The care plan contained an intervention initiated on 03/06/17 (typed as written): --"Monitor dialysis access for +bruit/+thrill q (every) shift and prn." Inquired about the location of dialysis AV shunt assessment documentation on 03/28/17 at 2:46 p.m. from Licensed Practical Nurse (LPN) #28 and LPN/wound nurse #19 due to being unable to locate documentation in the medical record. LPN #28 commented, "It should be in the TAR (treatment administration record) or the MAR (medication administration record), I will look." LPN/wound nurse #19 stated, "No it should be in her TAR, I will look." After searching the TAR, LPN/wound nurse #19 stated, "There is nothing in the TAR since her readmission to show that the AV shunt was monitored or assessed, there is not even a page in here for it to be monitored or assessed. I can't believe we missed it." Upon further inquiry LPN/wound nurse #19 stated, "As nurses, we all know if it is not documented then it wasn't done. No the physician order nor the care plan were followed		4. Center Nurse Executive/designee will provide a summary of findings and the action taken monthly to the Quality Improvement Committee for any additional follow-up and/or inservicing until issue is resolved and randomly thereafter.	

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	for monitoring or assessment of the shunt." .			
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329	F329 1. The laboratory drug test result was obtained, reviewed with physician and placed on the medical record for resident #41 on 3/28/17 by the Assistant Director of Nursing. 2. All residents of the facility have the potential to be affected. Audit completed of drug regimen reviews including laboratory drug levels requested to follow up on responses to monthly pharmacy reviews for all residents for the past three months by the Center Nurse Executive on 4/17/17, with corrective action upon discovery. 3. Re-education completed with Center Nurse Executive concerning need to ensure each resident's drug regimen was managed and monitored in order to promote or maintain the resident's highest practicable mental, physical, & psychosocial well-being including the management of residents' drug regimen reviews for laboratory drug levels requested to follow up on the responses to monthly pharmacy reviews to include results are placed in the resident's chart on 4/11/17 by the Clinical Quality Specialist. Post-test completed to validate understanding.	04/27/17

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	(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; . Based on record review, staff interview and facility policy review, the facility failed to ensure each resident's drug regimen was managed and monitored in order to promote or maintain the resident's highest practicable mental, physical, & psychosocial well-being. One (1) of five (5) residents reviewed for unnecessary meds did not have laboratory drug level results in the medical record. The facility was unaware of the absence of the laboratory drug levels and had no system in place to follow up on responses to monthly pharmacy reviews. Resident identifier: #41. Facility census: 61. Findings include: a) Resident #41 Review of the medical record, on 03/28/2017 3:07 p.m., revealed Resident # 41 received Theophylline 400 milligrams (mg) extended release (ER) once a day since admission for chronic obstructive pulmonary disease (COPD). The monthly pharmacy review, on 01/27/17, noted the resident was receiving Theophylline 400 mg daily for COPD. The recommendation stated, "Please consider monitoring a serum Theophylline concentration on the next convenient lab day and at least every 6 months thereafter." The physician accepted the recommendation on 02/01/17. On 02/03/17, the Director of Nursing (DON) wrote the following order: "Serum		Drug regimen reviews including requests for laboratory drug levels to follow up on responses to monthly pharmacy reviews and to ensure results are placed in the resident's chart will be audited monthly when received by Center Nurse Executive/designee x 3 months and then as determined by the Quality Improvement Committee. Results of audits will be reviewed randomly with the Center Executive Director/designee. 4. Center Nurse Executive/designee will provide a summary of findings and the action taken monthly to the Quality Improvement Committee for any additional follow-up and/or inservicing until issue is resolved and randomly thereafter.	

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	Theophylline concentration on next lab day then every 6 months. T.O. (telephone order) Dr. (name)/(name) RN (Registered Nurse)." The medical record contained the lab results for a basic metabolic panel drawn on 02/23/17 but lacked any information related to the Theophylline level. A follow up pharmacy review on 03/24/17, stated: "(Name) has orders for labs to be drawn, but at this time of this review they were not available in the resident record. The missing lab values include: 1. Serum Theophylline-February." The DON reviewed the medical record and pharmacy reviews during an interview on 03/28/17 at 4:33 p.m. She reported the Theophylline level was ordered on 02/03/17 and drawn on 02/06/17 and verified the chart did not contain a Theophylline level. The DON and Assistant Director of Nursing (ADON) acknowledged they were unaware the lab result were missing. The DON reported pharmacy recommendations are placed on the shelf for the physician to review. She stated she does not review them until after the physician and she had no system in place to monitor for responses and verify lab results are received. The facility policy titled Medication Regimen Review with a revision date of 12/12/16, stated the Center Nurse Executive or designee will ensure follow-up of the pharmacist recommendations. .			
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	F371	04/27/17

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	(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. . Based on observation, staff interview and facility master cleaning schedule, the facility failed to maintain an ice machine located in the residents' main dining room in a clean and sanitary manner. This practice affected residents' receiving ice from the ice machine and also residents' receiving meal service and consuming their meals in the dining room. Facility census: 61. Findings include: a) Observation		1. Ice machine's exterior covers on the machine vents located on either side of the machine, on the back of the ice machine and also along the border where the front cover is attached to the machine were cleaned immediately on 3/27/17 by Housekeeping Supervisor. 2. All residents of the facility have the potential to be affected. The Center has no other ice machines. 3. Re-education will be provided to Nutritional Service staff concerning the need to maintain the ice machine located in the residents' main dining room in a clean and sanitary manner including the daily cleaning of the ice machine's exterior covers on or before 4/27/17 by the Center Executive Director with posttest completed to validate understanding. Staff not available during this time period will be provided re-education including post-test upon return to work by the Center Executive Director/designee to include new hires during orientation. Audit of the cleanliness of the ice machine exterior covers will be completed by the Nurse Practice Educator/designee daily x 2 weeks including weekends, then 3 x per week x 2 weeks, then as determined by the Quality Improvement Committee. Results of audits will be reviewed randomly with the Center Executive Director/designee.	

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	During a dining observation in the main dining room, on 03/27/17 at 12:10 p.m., found an ice machine located in the dining room across from the food and tray serving area and beside tables where residents were consuming their noon meal. The ice machine was found to have a visible heavy accumulation of dust on the machine vents located on either side of the machine, on the back of the ice machine and also along the border where is front cover attached to the machine. The dining room contained forty-three (43) resident with sixteen (16) of those residents in close proximity to the machine. The observation was reported to the Administrator, and she agreed the ice machine needed cleaning. She stated, "I will have the girls clean this immediately. Yes this is also where the nurse aides get the residents ice from to refill water glasses and pitchers." At 12:16 p.m. on 03/27/17, the observed dust accumulation was shown to the interim certified dietary manager/corporate regional chef #92. He agreed the ice machine required cleaning. He stated, "Yes this is an issue with the dust or lint is blowing out of the vents across from where the food service is with resident trays being prepared and almost all of the residents are in here having lunch. The filter needs cleaned too and will contact maintenance to have them clean the machine and the filter as soon as the residents finish their meal." Housekeeping Supervisor #40 reported on 03/27/17 at 3:24 p.m., "We wipe the machine down every day but do not use a brush to clean the vents, but did today and will do it every day. I used a toothbrush to clean all the dust of the vents today."		4. Nurse Practice Educator/designee will provide a summary of findings and the action taken monthly to the Quality Improvement Committee for any additional follow-up and/or inservicing until issue is resolved and randomly thereafter.	

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	Requested the schedule of filter cleaning for the ice machine from Maintenance Supervisor, on 03/27/17 at 3:30 p.m. On 03/29/17 at 2:10 p.m. he reported that it was on his desk and would be given to me shortly. No documentation was received prior to survey exit. .			
F 508 SS=D	483.50(b)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS (b) Radiology and other diagnostic services. (1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. . Based on record review and staff interview, the facility failed to ensure diagnostic services were received in a timely manner to meet a resident's needs for diagnosis, treatment, and prevention. One (1) of five (5) residents reviewed for unnecessary meds did not have laboratory drug level results in the medical record. The facility was unaware of the absence of this lab and had no system in place to verify written notification of test results from the out source lab. Resident identifier: #41. Facility census: 61. Findings include: a) Resident #41 Review of the medical record, on 03/28/2017 3:07 p.m., revealed Resident # 41 received Theophylline 400 milligrams (mg) extended	F 508	F508 1. The laboratory drug test result was obtained, reviewed with physician and placed on the medical record for resident #41 on 3/28/17 by the Assistant Director of Nursing. 2. All residents of the facility have the potential to be affected. Audit completed of laboratory drug level results for all residents for the past three months to ensure results are reviewed with the physician and placed on the resident's chart in a timely manner by the Assistant Director of Nursing on 3/29/17, with no issues identified. 3. Re-education will be completed with licensed nurses concerning need to ensure diagnostic services were received in a timely manner to meet a resident's needs for diagnosis, treatment, and prevention including testing results are reviewed with the physician and placed on the resident's chart on or before 4/27/17 by the Nurse Practice Educator/designee with a posttest completed to validate understanding.	04/27/17

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	release (ER) once a day since admission for chronic obstructive pulmonary disease (COPD). On 02/03/17, the Director of Nursing (DON) wrote the following order: "Serum Theophylline concentration on next lab day then every 6 months." The medical record contained the lab results for a basic metabolic panel drawn on 02/23/17 but lacked any information related to the Theophylline level. The DON reviewed the medical record during an interview on 03/28/17 at 4:33 p.m. She reported the Theophylline level was ordered on 02/03/17 and drawn on 02/06/17, and verified the chart did not contain a Theophylline level. The DON and Assistant Director of Nursing (ADON) acknowledged they were unaware the lab result was missing. The DON admitted there was no system in place to monitor and verify lab results are received in a timely manner. .		Staff not available during this time period will be provided re-education including posttest upon return to work by the Nurse Practice Educator/designee to include new hires during orientation. Laboratory diagnostic testing results will be audited by the Center Nurse Executive/designee to ensure results are reviewed with the physician and placed on the resident's chart in a timely manner daily x 2 weeks including weekends, then 3 x per week x 2 weeks and then as determined by the Quality Improvement committee with corrective action upon discovery. Results of audits will be reviewed randomly with the Center Executive Director/designee. 4. Center Nurse Executive/designee will provide a summary of findings and the action taken monthly to the Quality Improvement committee for any additional follow-up and/or inservicing until issue is resolved and randomly thereafter.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that	F 514	F514 1. The Treatment Administration Record for resident #59 was updated to include monitoring for Arteriovenous (AV) shunt bruit and thrill every shift on 3/28/17 by	04/27/17

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	are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. . Based on record review and staff interview, the facility failed to maintain complete and accurate clinical records for one (1) of one (1) residents reviewed for dialysis. The facility failed to document the assessments of Resident #59's arteriovenous (AV) fistula/shunt every shift and as needed (prn) as ordered by the physician. Resident identifiers: #59. Facility census: 61. Findings include:		the Assistant Director of Nursing. 2. All residents of the facility have the potential to be affected. There are no additional residents in facility currently requiring dialysis services. 3. Re-education will be provided to all licensed nurses by Nurse Practice Educator/designee concerning need to maintain complete and accurate clinical records including monitoring dialysis Arteriovenous (AV) shunts on or before 4/27/17 with a posttest completed to validate understanding. Staff not available during this time period will be provided re-education including post-test upon return to work by the Nurse Practice Educator/designee to include new hires during orientation. A post-test will be completed to validate understanding. If the center would have a resident begin dialysis services, an audit of Treatment Administration Records will be completed by the Center Nurse Executive/designee to ensure that the physician order and care plan are followed daily x 2 weeks including weekends, then 3 x per week x 2 weeks, then as determined by the Quality Improvement committee. Results of audits will be reviewed randomly with the Center Executive Director/designee. 4. Center Nurse Executive/designee will provide a summary of findings and the action taken monthly to the Quality Improvement committee for any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515103	A. BUILDING _____ B. WING _____	03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	a) Resident #59 Review of the medical record, on 03/28/17 at 1:44 p.m., revealed Resident #59 was initially admitted to the facility on 03/04/17 and readmitted after a hospitalization on 03/21/17. Her diagnosis includes, end stage renal disease with dialysis. She has an AV shunt for dialysis access. On 03/21/17 a Physician order stated (typed as written) "Monitor dialysis graft every shift for bruit and thrill." Bruit is the sound of blood flowing through the AV shunt. Thrill is the vibration of blood going through the arm. The care plan contained an intervention initiated on 03/06/17 (typed as written): --"Monitor dialysis access for +bruit/+thrill q (every) shift and prn." Inquired about the location of dialysis AV shunt assessment documentation on 03/28/17 at 2:46 p.m. from Licensed Practical Nurse (LPN) #28 and LPN/wound nurse #19 due to being unable to locate documentation in the medical record. LPN #28 commented, "It should be in the TAR (treatment administration record) or the MAR (medication administration record), I will look." LPN/wound nurse #19 stated, "No it should be in her TAR, I will look." After searching the TAR, LPN/wound nurse #19 stated, "There is nothing in the TAR since her readmission to show that the AV shunt was monitored or assessed, there is not even a page in here for it to be monitored or assessed. I can't believe we missed it." Upon further inquiry LPN/wound nurse #19 stated, "As nurses, we all know if it is not documented then it wasn't done. No the		additional follow-up and/or inservicing until issue is resolved and randomly thereafter.	

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	physician order nor the care plan were followed for monitoring or assessment of the shunt." .			